Blue Ridge
Family Dentistry

824 W. Lamar Alexander Pkwy. • Maryville, TN 37801 • 865.379.7004
www.BlueRidgeDentistryOnline.com ♦ info@blueridge.dentist

2021

Patient Information

Today's Date _____

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred)

Gender: ☐ Male ☐ Female **Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth ____/____/_____ **SSN#** _____ **Email:** _____

Address: _____ (Street) _____ (City) _____ (St) _____ (Zip Code)

Phone: (____)_____ (Home) (____)_____ (Mobile) (_____)_____ (Work) (_____)_____ (Other)

Spouse or Guardian Information (if applicable)

Name: _____ (Last) _____ (First) ____ (MI)

Date of Birth: _____/_____/_____ **SSN:** _____ **Employer Name:** _____

Address: _____ (Street) _____ (City) _____ (St) _____ (Zip Code)

Phone: (_____)_____ **Cell:** (____)_____ **Work:** (_____)_____ **ext:** _____

Primary Dental Insurance Information

Insurance Company: _____ **Insured's Employer Name:** _____

Employer Address: _____ (Street) _____ (City) _____ (St) _____ (Zip Code)

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Date of Birth: _____/_____/_____ **Member ID #** _____ **SSN** _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address: of insured _____ (Street) _____ (City) _____ (St) _____ (Zip Code)

Name of person filling out this form: _____ (Printed Name) _____ (Signature)

Relationship to patient: ☐ Self ☐ Other (describe):_____

Requested Additional Information

☐ Check here if you have additional **Dental Insurance**. A supplemental insurance form will be provided for your convenience.

☐ Check here if we need to submit a **Records Request** to your former dentist. A form will be provided for your convenience.

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Financially Responsible Party *(Patient must sign if over 18 years old)* ☐ Check if this information is different from the insured

Name: _____ (Last) _____ (First) ____ (MI)

Gender: ☐ Male ☐ Female **Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: ____/____/_____ **SSN:** _____

Phone: (____)_____ **Cell:** (____)_____ **Work:** (____)_____ **ext:** _____

Address: _____ (Street) _____ (City) ____ (St) _____ (Zip Code)

Employer Name: _____ **Phone:** _____

Consent for Services & Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient will be determined before treatment, and that amount is due at the time of treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance agree that it is the patient's personal responsibility to pay for all dental services rendered. As a matter of convenience to the patient, the dental office will prepare and submit the necessary insurance forms and use reasonable efforts to collect from the patient's dental insurance carrier the benefits which are extended to the patient. All credits received will be applied to the patient's account. However, the patient understands and agrees that the dental office cannot do more than submit insurance claim forms and credit any payments received. The contract of insurance is between the patient and the patient's dental insurance company. If the dental insurance company pays nothing, or pays less than what the patient anticipated, the patient understands and agrees that it is the patient's responsibility to pay the balance owed. Further, the patient understands and agrees that any estimate of any benefit that may be paid by the patient's dental insurance company is purely an estimate and that the amount of any credit that will be ultimately applied will be the actual amount paid. Treatment estimates are based on applicable contracted insurance fee schedules. When insurance payment is denied due to plan limitations or exclusions, or when coverage is terminated, these denied charges will revert to Blue Ridge Family Dentistry's Usual and Customary Fees, and the patient is responsible for all applicable costs incurred. It is the patient's responsibility to keep scheduled appointments. Failure to show for an appointment or to notify Blue Ridge Family Dentistry of a cancelled appointment within 24 hours of the time allotted may incur a cancellation charge.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable legal & collection fees.

I also am giving consent to Blue Ridge Family Dentistry and staff to examine and treat my dental needs as deemed necessary.

I have read and fully understand the conditions of treatment and my personal financial responsibility and by signing herein below agree to those terms. In the event that I am not the patient, I agree to said terms on behalf of the patient as the patient's parent or legal guardian.

Authorization & HIPAA Release

I hereby certify that I have read and understand the previous information, and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize Blue Ridge Family Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

List of additional names we can release information to: _____

Signature of PATIENT, parent or guardian (Responsible Party): _____

Printed Name of Responsible Party: _____ **Date:** _____

Relationship to Patient: _____ **Patient's Name:** _____

Blue Ridge
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Molly K. Harriss, D.D.S. & Associates
824 West Lamar Alexander Pkwy
Maryville, TN 37801

Cancellation Policy

It is patient responsibility to keep all scheduled appointments. We understand that life can happen and this is not always feasible. We request that you please contact us no less than 24 business hours prior to any appointment that you will be unable to keep. Failure to notify us within 24 business hours may result in a cancellation fee. **Please be advised if you are 15 minutes past your scheduled appointment time we may need to reschedule your appointment.

Initial:_____

Insurance Disclaimer

Insurance companies **do not** guarantee any payment until they receive an actual claim of services. All treatment estimates are just that…estimates. We try to make every possible effort to give the most up to date information that your insurance company provides to us, however, it is impossible for us to know every exclusion and limitation for every insurance policy. If you have any questions or concerns about a treatment estimate you are more than welcome to contact your insurance for further clarification. We can also send your insurance company a predetermination for services if you so choose. Please be aware that this can take several weeks to get a response from your insurance company.

Initial:_____

I have read and understand BOTH the Cancellation Policy and Insurance Disclaimer. All questions I have regarding both have been answered.

Patient Signature:_____ Date:_____

Printed Patient Name:_____

Guarantor Name (If different from Patient):_____

Guarantor Signature:_____

Patient's Name

Blue Ridge Family Dentistry

/

Birth Date / Today's Date

HEALTH HISTORY FORM – Part I

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Allergies – Are you allergic to or have you had a reaction to any of the following? (If yes, please specify. Check DK for Don't Know)

	No	Yes	DK
Local Anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin/Other Antibiotics	☐	☐	☐
Barbiturates/Sleeping Pills	☐	☐	☐
Other (Explain)	☐	☐	☐

	No	Yes	DK
Metals/Nickel	☐	☐	☐
Latex (rubber)	☐	☐	☐
Hay Fever/Seasonal	☐	☐	☐
Codeine/Other Narcotics	☐	☐	☐

Do you have any of the following diseases or problems?

	No	Yes	DK
Active Tuberculosis	☐	☐	☐
Cough that produces blood	☐	☐	☐

	No	Yes	DK
Persistent cough greater than a 3 week duration	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information

Are you now under the care of a physician? ☐ ☐ ☐

Physician's Name _____

Physician's Address _____

Are you in good health? ☐ ☐ ☐

Has there been any change in your general health within the past year? ☐ ☐ ☐

If yes, what condition is being treated? _____

_____

_____

Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ ☐ ☐

If yes, why? _____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ ☐ ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

_____

Bone Health/Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ ☐ ☐ ☐

Are you scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from osteoporosis, Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date treatment began: _____

HEALTH HISTORY FORM – Part II

Patient Name _____ Birth Date / Today's Date _____ / _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. (Check DK if you Don't Know the answer.)

	No	Yes	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
**Unrepaired, cyanotic CHD*	☐	☐	☐
**Repaired (completely) in past 6 mos.*	☐	☐	☐
** Repaired CHD with residual defects*	☐	☐	☐
Heart attack (when?)_____	☐	☐	☐
High blood pressure	☐	☐	☐
Blood thinner usage	☐	☐	☐
Pacemaker/ICD	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date_____			
Hemophilia	☐	☐	☐
AIDS or HIV infections	☐	☐	☐
Arthritis (type)	☐	☐	☐
Dry mouth	☐	☐	☐
Mouth ulcers	☐	☐	☐

	No	Yes	DK
Autoimmune disease	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Cancer/Chemo/Radiation Tx	☐	☐	☐
Where on body?_____			
Tumors	☐	☐	☐
Low blood pressure	☐	☐	☐
Dizziness	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G. E. Reflux/heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Stroke	☐	☐	☐
TMJ disorder	☐	☐	☐

	No	Yes	DK
Hepatitis/jaundice/liverdisease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells/seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____	☐	☐	☐
Recurrent infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night Sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands (neck)	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Thyroid problems	☐	☐	☐
Glaucoma	☐	☐	☐
Head injuries	☐	☐	☐

**Except for the conditions noted above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

	No	Yes	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

	No	Yes	DK
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? VERY / SOMEWHAT / NOT INTERESTED			

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain: _____

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Signature of Patient/Legal Guardian | Printed Name | Date

FOR COMPLETION BY DENTIST

Comments: _____