Creekside Family Dentistry
New Patient Form

706 Lion Parkway
Columbia, TN 38401
Phone: 931-388-3384
Fax: 931-388-1883

PATIENT INFORMATION

Today's Date ____ /____ /____

Patient's Name _____

Preferred Name or Nickname _____

Birthdate ____ /____ /____ Age_____ ☐ Male ☐ Female

So. Sec. # _____

Driver's License No. _____

Mailing Address _____

City _____ State ____ Zip _____

Cell Phone _____

Home Phone _____

Email Address _____

Best way to confirm Appointment: ☐ Call ☐ Text ☐ Email

Referred By _____

Employer _____ How long? _____

Employer's Address _____

City _____ State ____ Zip _____

Occupation _____

Marital Status: ○ Minor ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse's Name _____

Do you have children? ☐ Yes ☐ No How many? _____

ACCOUNT INFORMATION *Person Responsible For Account*

☐ **Same as above**

Payment Method: ☐ Cash ☐ Check

Name _____

Relationship _____

Billing Address _____

City _____ State ____ Zip _____

Soc. Sec. No. _____

Driver's License No. _____

Work Phone No. _____

☐ INITIAL

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendeered. I fully understand I am solely responsible for any balaance not paid by my insurance company.

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Insurance Company _____

Address _____

City _____ State ____ Zip _____

Phone _____

Insured's Soc. Sec. No. _____

Group No. (Plan, Local, or Policy No.) _____

Insured's Name _____

Relationship _____ Birthdate ____ /____ /____

Insured's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Company _____

Address _____

City _____ State ____ Zip _____

Phone _____

Insured's Soc. Sec. No. _____

Group No. (Plan, Local, or Policy No.) _____

Insured's Name _____

Relationship _____ Birthdate ____ /____ /____

Insured's Employer _____

EMERGENCY INFORMATION

Whom should we contact in case of emergency?

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

Who is your medical Doctor?

Name _____

Phone No. _____

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation **Are you in pain?** ☐ No ☐ Yes How Long? _____

PLEASE INDICATE ANY OF THE FOLLOWING PROBLEMS:

☐ Discomfort, clicking or popping jaw
☐ Red, swollen or bleeding gums
☐ Sensitive tooth, teeth or gums
☐ Blisters/sores in or around the mouth
☐ Lost/broken filling(s)
☐ Teeth grinding
☐ Ringing in ears
☐ Broken/chipped tooth
☐ Stained teeth
☐ Locking jaw
☐ Bad breath
☐ Other:

Previous Dentist _____

Dentist's Phone No. _____

Last Dental Exam _____

Last Dental X-Rays _____

How many times do you brush each day? _____

How many times do you floss each day? _____

What type of toothbrush bristles do you use?

☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? *10 BEING BEST*

1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Do you require antibiotics before dental treatment?	☐ **Yes**	☐ **No**	☐ **Not Sure**	
Are you under a physician's care now?	☐ Yes	☐ No		Explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No		Explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No		Explain: _____
Are you taking any medications, pills or drugs?				
Are you on an aspirin regimen or taking any type of blood thinner?	☐ Yes	☐ No		If Yes, Please list: _____
Have you ever taken Fosamax, Bonivaa, Actonel or any other medicaations containing bisphosphonates?	☐ Yes	☐ No		
Are you pregnant or trying to get pregnant?	☐ Yes	☐ No	☐ Nursing	
Taking oral contraceptives	☐ Yes	☐ No	☐ N/A	
Do you use tobacco?	☐ Yes	☐ No	☐ N/A	
Do you use controlled substances?	☐ Yes	☐ No	☐ N/A	

If you are allergic to any of the following, please circle:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Other: _____

Please indicate if you have or have ever had any of the following:

☐ AIDS/HIV Positive	☐ Cancer	☐ Excessive thirst	☐ Hepatitis A	☐ Osteoporosis	☐ Spinal bifida
☐ Alzheimer's disease	☐ Chemotherapy	☐ Fainting spells/dizziness	☐ Hepatitis B or C	☐ Pain in Georgia points	☐ Stomach/intestinal
☐ Anaphylaxis	☐ Chest pains	☐ Frequent Cough	☐ Herpes	☐ Parathyroid disease	☐ disease
☐ Anemia	☐ Cold sores/fever blisters	☐ Frequent diarrhea	☐ High blood pressure	☐ Psychiatric care	☐ Stroke
☐ Angina	☐ Congenital heart disorder	☐ Frequent headaches	☐ Hives or rash	☐ Radiation treatments	☐ Swelling of limbs
☐ Arthritis/gout	☐ Convulsions	☐ Genital herpes	☐ Hypoglycemia	☐ Recent weight loss	☐ Thyroid disease
☐ Artificial heart valve	☐ Cortizone medicine	☐ Glaucoma	☐ Irregular heartbeat	☐ Renal Dialysis	☐ Tonsillitis
☐ Artificial joint	☐ Diabetes	☐ Hayfever	☐ Kidney problems	☐ Rheumatic fever	☐ Tuberculosis
☐ Asthma	☐ Drug addiction	☐ Heart attack/failure	☐ Leukemia	☐ Rheumatism	☐ Tumors or growths
☐ Blood disease	☐ Easily winded	☐ Heart murmur	☐ Liver disease	☐ Scarlet fever	☐ Ulcers
☐ Blood transfusion	☐ Emphysema	☐ Heart pacemaker	☐ Low blood pressure	☐ Shingles	☐ Venereal disease
☐ Breathing problem	☐ Epilepsy or seizures	☐ Heart trouble/disease	☐ Lung disease	☐ Sickle cell disease	☐ Yellow jaundice
☐ Bruise easily	☐ Excessive bleeding	☐ Hemophilia	☐ Mitral valve prolapse	☐ Sinus trouble	

Have you ever had any other serious illness not listed above? ☐ Yes ☐ No Comments _____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE

DATE

○ ADULT PATIENT
○ PARENT/GUARDIAN
○ SPOUSE

Consent for use and Disclosure of Health Information

706 Lion Parkway
Columbia, TN 38401
Phone: 931-388-3384
Fax: 931-388-1883

Section A: Patient giving consent

NAME:

Section B: To the Patient

Please read the following statements carefully

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Oour Notice proves a description of our treatment, payment activities and healthcare information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:
Tammy McPeak
706 Lion Parkway
Columbia, TN 38401
931-388-3384 or 931-388-1250 (fax)

Right to Revoke:
You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person(s) listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Please Sign and Return:

I,

have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE:

DATE:

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

REPRESENTATIVE'S NAME:

RELATIONSHIP TO PATIENT:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed consent in the patient's chart.