

DEVO†ED DENTISTRY

1280 Dow Street • Murfreesboro, TN 37130 615-893-9433

20			
Name: Last	First	MI	Mr Mrs. Ms Di
I prefer to be called:			
Birthdate:// _	Age:	_ SS#:	
Home Address:			
			Apt/Condo
City	State		Zip
Single Marrie	d Divorced	Widowed	Separated
Hm #: ()	Work	#: ()	ext
Cell #: ()	Text?	Yes	No
Email:			
Employer:			
How long there?	Occupation: _		
Where & when are best to	imes to reach you?		
Whom may we thank for	referring you?		
Other family members se	en by us:		
Previous / Present Dentis (Please circle)	t:		
Last visit date:			
	Emergency	Contact	
Mana			

2 DENTAL INSURANCE
Primary Dental Insurance
Insurance Co. Name:
Insurance Co. Phone:
Insured's Name:
Insured's Employer:
Insured's Birthdate:
Insured's SSN:
Secondary Dental Insurance
Insurance Co. Name:
Insurance Co. Phone:
Insured's Name:
Insured's Employer:
Insured's Birthdate:
Insured's SSN:

Please note that we only file up to two insurances per patient. We file your insurance as a courtesy. Any estimates given are based on information given by your insurance company, and are not a guarantee of benefits. Final determination of benefits is made by the insurance company. You are responsible for any and all amounts not paid by your insurance company.

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Signature

/				2353	
Are	you	currently under the care of a Physician	?	_Yes	sNo
	Nan	ne and Number of Physician:			
Las	st ch	eckup date (approximate):			
На	ve y	ou ever been hospitalized or had a majo	r oper	atior	n?YesNo
ام	VO 1/	ou over been told to take a 'Ore Med' or	antibi	odia v	rior to dontal visita due to Artificia
		ou ever been told to take a 'Pre-Med' or		ouc p	onor to dental visits due to Artificia
Joi	nts/E	Bones or Mitral valve?YesN	0		
Do	you	smoke or use any type of tobacco prod	ucts?		_YesNo
Are	you	taking blood thinners (Aspirin, Warfarin	/Coun	nadir	Plavix Pradaxa)?
		sNo	w Oodii	ician	i, i idvin, i roddind):
_	16	SNO			
На	ve y	ou ever taken any type of bone density r	medica	ation	s (Bisphosphonates-Fosamax,
999		Actonel, Reclast) or Methotrexate?			
	100000				
Ple	ase	list any serious medical condition(s) tha	t you h	nave	ever had:
	_		922		
Are	you	taking birth control pills?Yes	No		
Pre	gna	nt or trying to get pregnant?Yes		No	
Nu	rsing	?YesNo			
					227 97 700 22
		Have you ever had any of the followi	ing dis	eas	es or medical problems?
Y	N	AIDS/HIV+	Υ	N	Heart Surgery
Y	N	Abnormal or Excessive Bleeding	Υ	N	Heart Pacemaker
Y	N	Alcohol or Drug Abuse -past or present	Υ	N	Heart Murmur
Υ	N	Anaphylaxis	Υ	N	
Y	N	Anemia	Y	N	Hepatitis B or C
Y	N	Angina/Chest Pains	Y	N	Herpes
Y	N	Anorexia or Bulimia	Υ	N	High Blood Pressure
Y	N	Arthritis/Gout	Υ	N	Hives or Rash
Y	N	Artificial Bones/Joints/Valves	Υ	N	Kidney Problems
Y	N	Asthma	Υ	N	Liver Disease
Y	N	Blood Transfusion	Υ	N	Low Blood Pressure
Y	N	Bruise Easily	Υ	N	Mitral Valve Prolapse
Y	N	Cancer or Radiation or Chemotherapy	Υ	N	Psychiatric Treatment or Medication
Y	N	Cold Sores/Fever Blisters	Υ	N	Renal Dialysis
Y	N	Colitis or Stomach Problems	Υ	N	Rheumatic or Scarlet Fever
Y	N	Congenital Heart Disorder	Υ	N	Recent Weight Loss
Y	N	Diabetes	Υ	N	Shingles
Y	N	Breathing Problems	Υ	N	Sickle Cell Disease
Y	N	Easily Winded	Y	N	Sinus Problems
Y	N	Emphysema or COPD	Υ	N	Steroid Medication (Cortisone)
Y	N	Epilepsy or Seizures or Convulsions	Υ	N	Stroke
Y	N	Fainting Spells or Dizziness	Υ	N	Thyroid Issues
Υ .	N	Frequent headaches	Υ	N	Tuberculosis (TB)
1	N	Glaucoma	Υ	N	Ulcers
Υ	N	Heart Attack		N	Venereal Disease

		Are yo	ou alle	erg	ic to any of the foll	lowing?		
/ N	1	Aspirin	Υ	N	Erythromycin	Υ	N	Tetracycline
/ N	1	Codeine	Υ	N	Latex	Υ	N	Other
/ N	ı	Dental Anesthetics	Υ	N	Penicillin			

5 MEDICATIONS
Please list ALL medications you are currently taking including OTC and Supplements:
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I understand that I am financially responsible for all payments not covered by insurance. I agree to pay all collection and/or attorney's fees and costs should my account become delinquent and any legal action be taken. I understand that any unpaid balance over 60 days will accrue interest at the maximum amount permitted by law. Minimum billing charge \$3.00.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Grant Dillingham, DMD PLLC, dba Devoted Dentistry, for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I have read and agree to the terms of the Privacy Practices I want a copy I do not want a copy.

Date