# New Patient Registration

**Patient Name:**_____ **LastName:**_____ **Middle Initial:**_____

**Patient is:** ☐Policy Holder
☐Responsible Party

**Preferred Name:**_____

**Responsible Party Name** (if other than the patient)**First:**_____ **Last:**_____
Is Responsible Party's address the same as the Patient? ☐Yes ☐No (If no, please provide on the back of form)

**Patient Information:**
Street Adress:_____ City:_____ State:_____ Zip code:_____

Home Phone:_____ Work Phone:_____ Cell phone:_____

Email Address:_____ **May we contact you via? Text ☐ Email ☐ Both ☐**

**Sex:** ☐ Male ☐ Female **Marital Status**: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Birth Date:_____ Age:_____ Soc. Sec._____ Drivers. Lic:_____

**Insurance Information:**
Name of Insured: _____ Relationship: ☐Self ☐Spouse ☐Child ☐Other_____

Insured Soc. Sec._____ Insured Date of Birth:_____

Employer: _____ Insurance Company:_____

Address: _____ City: _____ State:_____ Zip code:_____

**Dental Questionnaire**:
Date of last Dental Exam:_____ Date of last Dental Cleaning:_____

Are you experiencing any pain or sensitivity with any of your teeth?_____ If yes, for how long?:_____
Have you tried anything to help with the pain/sensitivity?:_____ If yes, how is it working?:_____

Are you having any specific dental concerns today?_____

Is there anything specific you would like us to focus on today?:_____

On a scale of 1-10, with 10 being the best, how would you rate your overall smile and condition of your teeth?:_____
What would you like them to be?:_____

Please circle if you have had any of the following:

Bad Breathe
Bleeding gums
Blisters on gums or lips
Burning sensation with tongue
Chewing on fingernails or objects
Clicking or popping in your jaw
Dry Mouth
Food collection in between teeth
Grinding of teeth
Gums swollen or tender
Loose teeth
Broken fillings
Sensitivity to cold
Sensitivity to hot
Sensitivity to sweets
Orthodontic treatment
Periodontal treatment
Gum surgery
How often do you brush?_____
How often do you floss?_____

**Emergency contact person: Name:** _____ **phone number**_____

**Who may we thank for your referral?**_____

# Back 2 Basics Dentistry

## HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pace Maker ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No | Yellow Jaundice ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No | |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been treated with Bisphosphonate drugs such as: Fosamax, Aredia, Zometa, Actonel, Boniva? If so when did the treatment begin? _____

Please list any medications you are currently taking and dosages, or you may provide us with a list to scan into your chart:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose i.e. vitamins, antacids etc:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Have you ever been diagnosed with sleep apnea? Yes No If yes, do you use a CPAP and are you happy with it? Yes No

**Are you interested in Sedation Dentistry**: Yes No

**If yes, please answer the following questions to the end of the questionnaire:**

Are you taking any of these medications: (please circle if yes)

| | |
|---|---|
| Antacids | Tagamet (cimetidine) or Prilosec (omeprazole) |
| Dilantin or Tegretol | Serzone (nefazodone) |
| Barbituates | Diflucan (fluconazole) or Sporonox (itraconazole) |
| St. John's wort or Kava-Kava | Biaxin (clarithromycin) |

Do you consume grapefruit juice on a regular basis? Yes No

Tobacco, Alcohol, Drugs

| | | |
|---|---|---|
| Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long? | No | Yes |
| Do you want to quit using tobacco? | No | Yes |
| Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? | No | Yes |
| Do you use any mood altering drugs other than those previously listed? | No | Yes |

Weight and Diet considerations

| Weight | Meals per Day | Dietary Restrictions | Food Allergies |
|---|---|---|---|
| | | | |
| Sugar in your diet (circle one): *none slight moderate high* | | | |

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

_____ _____ _____

*Patient (Print Name)* *Patient Signature* *Date*

# Back To Basics Dental Center, L.L.C.

## D.B.A. Back 2 Basics Dentistry

*Your Privacy Is Important to Us*

## Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Back 2 Basics Dentistry. I hereby authorize, as indicated by my signature below, Back 2 Basics Dentistry, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

**Please check your preferred means of communication:**

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Date __/__/____ Relationship: _____

2. _____ Date __/__/____ Relationship: _____

3. _____ Date __/__/____ Relationship: _____

4. _____ Date __/__/____ Relationship: _____

* * *

**For Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

## PATIENT CONSENT

**Clinical**

1. I authorize **BACK TO BASICS DENTAL CENTER, L.L.C.**, to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

**Financial**

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.8% MPR will be automatically tabulated into my account if my balance is 30 days old or older. I will also have a $2.00 per month billing charge of $2.00. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

5. A $40 per hour missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

**Insurance**

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name: _____ Date: _____

Patient's Address: _____

Signature: _____ Relationship: _____ Date: _____

If patient is a child, please provide the parental or legal guardian's consent:

***NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.***

**Back 2 Basics Dentistry**
**Acknowledgement of Office Policies**

_____I hereby authorize the release of any information necessary to process an insurance claim and request direct payment to Back to Basics Dental Center.

_____Fees are to be paid at the time the services are performed.

_____It is my responsibility to understand my dental insurance. Back 2 Basics Dentistry is only given an estimate of my coverage through my insurance company. I am responsible for any balance my insurance does not pay.

_____Our dentists base treatment recommendations on your needs, not what your insurance covers.

_____ If I require a procedure that requires two or more hours I will be asked to put a deposit of $100.00 that will go towards my dental procedure.

_____Based on Tennessee state law children under the age of 18 must be accompanied by a parent or legal guardian to ALL dental appointments.

_____I understand that children should not be brought with an adult when the adult has the scheduled appointment. It is not in the best interest of the child, the adult patient, nor our staff.

_____I understand that if I am over 18 years old any issues regarding my treatment and or my account cannot be discussed with family members or friends unless I specify in writing. All other communications will be in accordance with the HIPAA guidelines. (Please ask the front desk patient coordinator for more information if you wish to add your spouse or family member)

_____Under normal circumstances dental work completed in our office is guaranteed for one year providing that I take appropriate care of my mouth, received regular six month check ups and have regular cleanings.

____I understand that my dental record information belongs to me but my dental records, radiographs, photos, and study models are the property of Back to Basics Dental Center, LLC. If I request dental records, I am aware there will be a standard fee of $20 for these records.

_____I understand that if a check written for my account to Back to Basics Dental Center is returned for insufficient funds, a returned check fee of $30.00 will be added to the original balance of my check and I am responsible for paying this amount prior to any further dental appointments.

_____I understand that should my account balance not be paid in a timely manner, it will be turned over to our collection agency. I will be responsible for any billing, finance, legal or collection fees, which may occur.

_____I understand that I may be charged $40.00 for appointments cancelled with less than 24 hours notice prior to my next visit except in case of emergencies or serious illness. I understand that I will not be given any other dental appointments until this balance is paid. I further understand that my insurance company will not pay for this charge.

_____I understand that if I miss three (3) appointments without 24 hours notice of cancellation, I may be discharged from the practice.

Witness_____ Printed Name_____

Signature_____

Date of signature_____

Back to Basics Dental Center, LLC, DBA Back 2 Basics Dentistry

Back 2 Basics Dentistry
1762 Hwy 48
Clarksville, Tn 37040
931-645-8000

# Photo and Video Release

Date: _____

Name: _____

I hereby

☐ Authorize

☐ Do not authorize

the use and reproduction by Back 2 Basics Dental Center, LLC, DBA Back 2 Basics Dentistry, of any and all photographs and/or videos which have been taken of me without further compensation to me. All negatives, positives, digital files, etc. shall constitute property of Back 2 Basics Dentistry solely and completely.

_____

**Signature**

# Oral Cancer Screening Consent Form

We are very concerned about oral cancer, and conduct screening examinations on every patient.

The Incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that in 2007, they expect a remarkable 11% increase in this deadly disease. Alarmingly, 25% of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age and tobacco and alcohol use.

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the VELscope has received FDA approval. The VELscope (for Visually Enhanced Lesion scope) will help up pinpoint and identify suspicious tissue at earlier stages before they may become life-threatening concerns.

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage. Before the exam, the room is darkened and much like "dessert storm night vision technology" the clinician can see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurances. The fee for this enhanced examination is **$20.00**. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.

Please sign the area below to accept the financial responsibility for this procedure.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

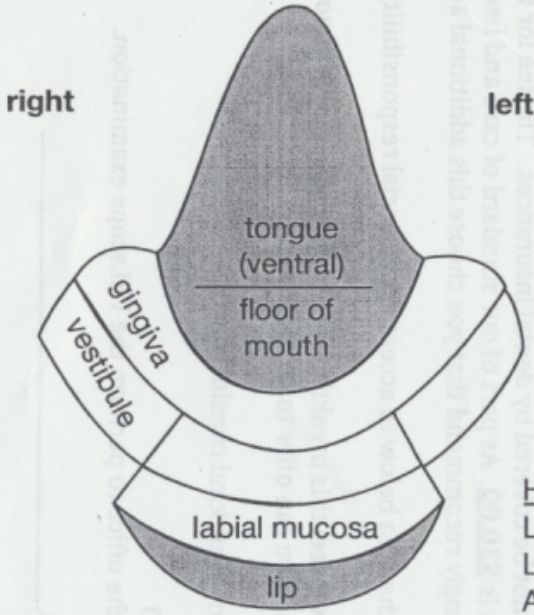
YES NO
I authorize the office to perform the VELscope examination.

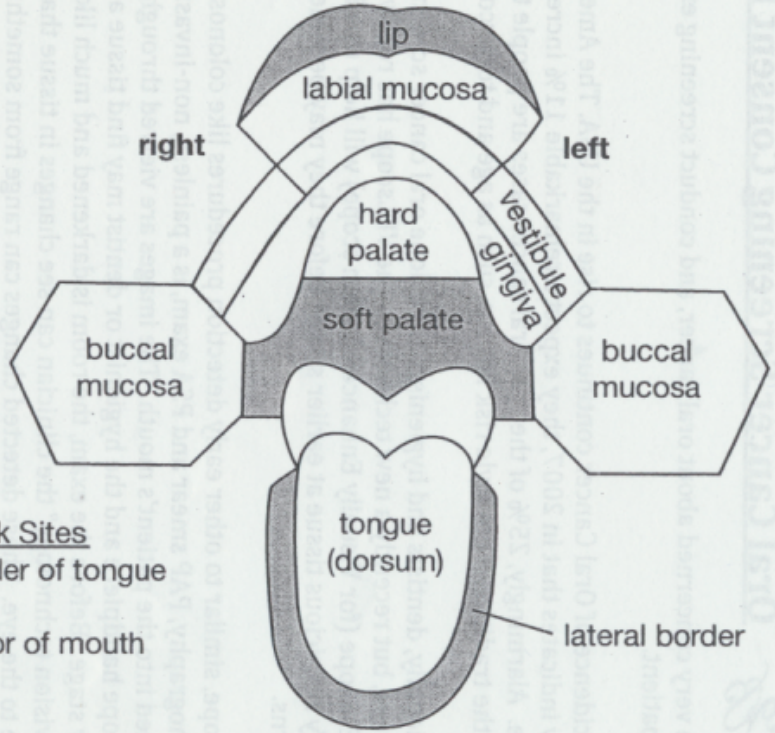
Print Name:_____

Signature:_____ Date:_____

Patient _____ ID _____

Clinician _____ Date _____




Highest Risk Sites
Lateral border of tongue
Lip
Anterior floor of mouth
Soft palate