CUMBERLAND TRAILS
— FAMILY DENTAL —
Christopher Williams, DDS
Candice Denison, DDS

Date _____

Name _____ Date of Birth _____

Social Security # _____ Driver's License # _____ State _____

Address _____

City _____ State _____ Zip _____

Phone #'s (H) _____ (C) _____ (W) _____

Email _____

Please Circle: Minor Single Married Divorced Widowed Separated

Preferred Pharmacy _____

Pharmacy Address _____

Employer _____ Employer Phone # _____

Spouse/Parent's Name _____ Employer _____

School/College (if a student) _____

Emergency Contact _____ Phone _____

Whom or what may we thank for referring you? _____

Insurance Information (if applicable)

Subscriber Name _____

Relationship to Patient _____ Subscriber Date of Birth _____

Social Security # _____ Member ID _____

Employer _____

Insurance Company Name _____ Group # _____

Insurance Phone #'s for Benefits/Providers _____

Acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication

Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

This form allows Cumberland Trails Family Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used to carry out treatment, payment, or health care options.

Cumberland Trails Family Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing of this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Cumberland Trails Family Dental.

I understand that at anytime I have the right to revoke this consent provided I do so in writing, but Cumberland Trails Family Dental may still use information to complete any actions it began prior to my revoking consent and which rely on my protected health information. I understand Cumberland Trails Family Dental may refuse service if I revoke this consent.

I understand I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided to me in writing. I understand that while Cumberland Trails Family Dental is not required to agree to my requested restrictions, the practice is bound by that agreement if it does agree.

By my signature below I affirm the above information.

Patient Signature _____ Date _____
Parent Signature (if minor) _____ Date _____
Authorized Representative _____ Date _____

_____ Initials I hereby authorize Cumberland Trails Family Dental to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; 2) Information related to billing and payment.

_____ Initials I hereby authorize Cumberland Trails Family Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Email _____ Home Phone _____ Office Phone _____ Cellphone

_____ Initials I hereby authorize Cumberland Trails Family Dental may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

_____ Initials I hereby authorize Cumberland Trails Family Dental may disclose my personal health information to the person whom I have listed as my emergency contact.

_____ Initials I hereby authorize Cumberland Trails Family Dental may disclose my personal health information to the following person(s):

Name	Phone Number	Relationship to Patient

MEDICAL HISTORY

Date _____

Patient Name _____ Preferred Name _____ Age _____

Name of Physician _____ Most recent physical exam _____

Reason _____

Circle an estimate of your general health: Excellent Good Fair Poor

Have you ever had an allergic reaction to:

Clindamycin	Yes	No		Codeine	Yes	No
Erythromycin	Yes	No		Ibuprofen	Yes	No
Latex	Yes	No		Penicillin	Yes	No
Sulfa	Yes	No		Tetracycline	Yes	No
Tramadol	Yes	No		Tylenol	Yes	No

Other _____

Please check yes or no to the following questions. Note the date if any answer is yes.

No	Yes	Date	
____	____	_____	Hospitalization for illness or injury in the last 2 years?
____	____	_____	Heart problems, or surgery, within the last 6 months?
____	____	_____	Can you walk up a flight of stairs without having to stop and rest, or getting short of breath?
____	____	_____	History of uneffective endocarditis?
____	____	_____	Artificial heart valve or repaired heart defect (PFO)?
____	____	_____	Pacemaker or implantable defibrillator?
____	____	_____	Artificial prosthesis (heart valve, joints, hip or knee replacement)?
____	____	_____	High blood pressure?
____	____	_____	Low blood pressure?
____	____	_____	Stroke?
____	____	_____	COPD?
____	____	_____	Tuberculosis?
____	____	_____	Asthma?
____	____	_____	High cholesterol or taking statin drugs?
____	____	_____	Diabetes Type 1?
____	____	_____	Diabetes Type 2?
____	____	_____	Are you taking anything for Osteoporosis (soft bones, i.e. bisphosphonates)?
____	____	_____	Is it uncomfortable for you to sit in a dental chair in a laid-back position?
____	____	_____	Epilepsy or convulsions?
____	____	_____	Hepatitis Type A, B, C, D, or E (please circle if applicable)?
____	____	_____	Blood thinners?
____	____	_____	Kidney disease?
____	____	_____	Liver disease?
____	____	_____	Dizziness/history of fainting?
____	____	_____	HIV/AIDS?
____	____	_____	Have you undergone chemotherapy or radiation therapy?
____	____	_____	Smoker, previous smoker, or use smokeless tobacco?
____	____	_____	Pregnant?

Do you have any health issues that we need to discuss, or could possibly affect your dental treatment? If yes, please explain.

_____

Please legibly list all medications, supplements, and/or vitamins taken within the last 2 years (or provide a list to the office):

_____

_____

Patient Signature _____ Doctor Signature _____ Date _____

DENTAL HISTORY

Date _____

Full Name _____ Date of Birth _____

How would you rate the current condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long were you a patient? _____

Date of Most Recent: Exam _____ X-Rays _____ Treatment _____

What is your immediate concern? _____

On a scale of 1 (least) to 10 (most), how fearful are you of dental treatment? 1 2 3 4 5 6 7 8 9 10

Please check yes or no to the following questions

Yes	No	
____	____	Have you ever had an unfavorable dental experience?
____	____	Have you ever had complications from past dental treatments?
____	____	Have you ever had trouble getting numb, or had any reactions to local anesthetic?
____	____	Did you ever have braces, orthodontic treatment, or had your bite adjusted?
____	____	Have you had any teeth removed?

Smile Characteristics

____	____	Is there anything about the appearance of your teeth you would like to change?
____	____	Have you ever whitened (bleached) your teeth?
____	____	Have you been disappointed with the appearance of your previous dental work?

Bite and Jaw

____	____	Do you have problems with your jaw joint, i.e. pain, sounds, limited opening, locking, etc.?
____	____	Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
____	____	Are your teeth crowding or developing space?
____	____	Do you clench your teeth in the daytime or make them sore?
____	____	Do you have any problems with sleep, or wake up with an awareness of your teeth?
____	____	Do you wear, or have you ever worn, a bite appliance?

Tooth Structure

____	____	Have you had cavities within the last 3 years?
____	____	Do you seem to have too little saliva, or have difficulty swallowing food?
____	____	Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?
____	____	Are any teeth sensitive to hot, cold, biting, or sweets?
____	____	Do you avoid brushing any part of your mouth?
____	____	Do you have grooves or notches on your teeth near the gumline?
____	____	Have you ever broken teeth, chipped teeth, or had a toothache and cracked filling?
____	____	Do you frequently get food caught between any teeth?

Gum and Bone

____	____	Do your gums bleed, or are they painful while brushing or flossing?
____	____	Have you ever been treated for gum disease, or been told you have lost bone around your teeth?
____	____	Have you ever noticed an unpleasant taste or odor in your mouth?
____	____	Has anyone in your family had a history of periodontal disease?
____	____	Have you ever experienced gum recession?
____	____	Have you ever had any teeth come loose on their own (without an injury)?
____	____	Have you experienced a burning sensation in your mouth?

Cumberland Trails Family Dental
Dental Benefits and Explanation

The patient is responsible for:

- Understanding their insurance coverage.
- Informing the office of any changes in their insurance coverage.
- Cumberland Trails Family Dental will submit dental claims to your insurance carrier. We also accept benefit assignments, meaning we will **estimate** the expected benefit payment and allow you to pay your **estimated** portion at the time services are provided.
- Cumberland Trails Family Dental requires a $50 deposit to schedule treatment. This deposit allows us to know patients will be coming to appointments as scheduled so we can confidently reserve time for you. The $50 deposit applies to your final fee if you arrive for your appointment. The remaining patient portion is due the day services are rendered.
- Cumberland Trails Family Dental is exuberantly committed to providing accurate estimates of insurance benefits. However, **patients are fully responsible for any balance due after insurance has paid their portion. We take no responsibility for any denials by patient dental plans.**

Any services we provide cannot be billed to Medicaid or DHMO dental insurance plans.

Payment Options

Payment for the patient's portion is due in full on the date of service. Payment may be made by cash, check, Visa, Mastercard, Discover, American Express, or an outside dental financier.

Cancellation and Rescheduling Policy

Cumberland Trails Family Dental strives to provide quality dental care in a timely manner. When we schedule an appointment for you, we reserve time for you. Because of this, we require 24 hours notice to cancel or reschedule an appointment. Last-minute cancellations and rescheduling results in open time that we cannot utilize to serve another patient. **If appointments are cancelled or rescheduled in less than 24 hours, a $50 fee will be accessed.** Any plans presented for treatment are valid for 90 days on the date of presentation. Prepayment may be required if you cancel 2 or more times without a proper 24-hour notice.

Our Commitment to You

If, within 3 years, our crowns porcelain veneers, or onlay(s)/inlay(s) break or fracture – and the tooth or teeth are still viable, and you fulfill your commitment (written below) – we will replace any crowns, porcelain veneers, or onlays/inlays with the same type of material at no charge.

Your Commitment

- In order for full-fee replacement to be honored, you need to visit our office a minimum of 2 times per calendar year for professional cleanings, the evaluation of restorations, and oral cancer screenings.
- If recommended periodontal disease (gum disease) treatments are necessary, 3 to 4 periodontal maintenance cleanings per calendar year will be needed.
- Patients with certain systemic diseases or complications, taking chemotherapy or radiation therapy, or medications causing dry mouth may also invalidate warranty.

Please read the following authorization and sign for our files

I hereby authorize the release of any dental information necessary to process insurance claims or be referred to dental or medical offices. I authorize payment of benefits to the dentist described herein for services rendered. I have also read the above sections and agree to the terms therein.

_____ _____ _____

Name (Printed) Signature Date