COSMETIC & GENERAL DENTISTRY
12 SOUTH DENTAL STUDIO
NASHVILLE TENNESSEE

welcome

Date_____

Name_____ Birthdate_____ ☐ Male ☐ Female

Preferred Name_____ Social Security Number_____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____ Ext. _____

Email_____

Preferred method of contact (Circle: Home / Cell / Work / Text / Email)

Spouse Name_____His/Her Employer_____

Person to contact in case of an emergency

Name_____ Phone_____

Favorite music artist / Pandora station _____

How did you find out about our office?_____

Dental Insurance

Insured's Name_____ DOB_____ SS#_____

Insured's Employer_____

Insurance Co_____

Insurance Co Address_____

Phone #_____ Policy/ID #_____

Group #_____ Insured's SS#_____

Relationship to Insured (Circle: Self / Spouse / Parent / other _____)

Name_____

Date_____

Medical History

Do you have a personal physician? Yes / No Physician's Name _____

Your current health is Good / Fair / Poor

Are you currently taking any prescription or over-the-counter medications? Yes / No

Please list _____

_____ Please use reverse

_____ side if needed.

_____

Have you ever had any of the following diseases or medical conditions?

Y	N	Abnormal Bleeding	Y	N	High Blood Pressure
Y	N	Acid Reflux	Y	N	HIV+/AIDS
Y	N	Alcohol/Drug Abuse	Y	N	Hypoglycemia
Y	N	Anemia	Y	N	Kidney Problems
Y	N	Artificial Joints/Bones/Valves	Y	N	Leukemia
Y	N	Asthma	Y	N	Liver Disease
Y	N	Cancer	Y	N	Low Blood Pressure
Y	N	Chemotherapy	Y	N	Migraines
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Rheumatic Fever
Y	N	Epilepsy/Seizures	Y	N	Scarlet Fever
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Heart Attack	Y	N	Sickle Cell Disease
Y	N	Heart Murmur	Y	N	Sinus Problems
Y	N	Heart Surgery	Y	N	Stroke
Y	N	Hemophilia	Y	N	Thyroid Problems
Y	N	Hepatitis A / B / C	Y	N	Tuberculosis (TB)
Y	N	Cold Sores/Fever Blisters	Y	N	Ulcers

Do you need to be pre-medicated for Mitral Valve Prolapse, Heart Murmur, or Prosthetic Joint? Y N

Do you smoke? Y N

For Women: Are you Pregnant? Y N

Are you nursing? Y N

Are you allergic to any of the following (please circle)?

Aspirin	Erythromycin	Sulfa Drugs
Codeine	Penicillin	Latex
Dental Anesthetics	Tetracycline	Other_____

Name_____

Date_____

Dental History

Previous/present Dentist_____ Last dental visit_____

Your current dental health is: good fair poor

Reason for today's visit_____

Y N Do you feel you are meticulous with your oral hygiene?
Y N Do you understand the correlation between plaque control and the prevention of gum disease?
Y N Have you noticed that you grind your teeth at night?
Y N Do you have frequent or regular headaches?
Y N Are your jaw joints or muscles ever sore or tender?
Y N Have you ever worn a splint or nightguard?
Y N Would you like to keep your natural teeth for as long as you live?
Y N Do you get frustrated that you need work done every time you go to the dentist?
Y N Would you like to have whiter teeth?
Y N Are your teeth prone to having decay (cavities)?
Y N Do you have silver or discolored fillings that you are unhappy with?
Y N Do you have crowns or bridges that are unattractive or unnatural looking?
Y N Do you sometimes feel uncomfortable with the appearance of your smile?
Y N Are your teeth crooked or crowded?
Y N Would you like them to be straighter?
Y N Do you have one or more missing teeth?
Y N Do you have unattractive spaces between you teeth?
Y N Do you think a more attractive smile would improve your personal and/or professional relationships?
Y N Do you often feel as if your breath is not as fresh as it could be?

What level of dental care do you think your dental insurance company pays for?

Poor ..... Fair.....Excellent

What level of dental care would you like to have for yourself?

Poor ..... Fair.....Excellent

I understand that the information that I have given 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 charges whether or not paid by insurance. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature_____Date_____

our privacy pledge

We are always mindful of protecting your privacy and will continue to do so. The law requires us to provide you with this disclosure outlining how we handle your personal health information. Please review the following and acknowledge receipt of your policies with your signature below. If you have any questions about your privacy, please ask any of our team members for more information.

There are several circumstances in which we may need to use or disclose your health information.

- We may disclose your personal and health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your dental condition.
- We may disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control purposes or in order to provide optimal comfort and care.
- We may need to access your name, address, phone numbers, and clinical information in order to contact you with appointment reminders, information about treatment, or updated information that may be of interest to you.
- We may disclose information about your completed treatment as requested by your insurance company's representatives in order to facilitate settlement of claims for you reimbursement.

We reserve the right to change our privacy practices as described above. If we make any changes to our privacy policy, you will be notified in writing by mail or when you come to our office. If you have specific questions about how we handle your health information or how our policy relates to a particular situation, please feel free to ask us at any time.

Your Right to Limit Uses or Disclosures
You have the right to request that we not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. If we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization
You may revoke your consent at anytime; however, your revocation must be in writing. We will not be able to honor your request if your health information has been released prior to receiving your written request.

I have read you consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____
Patient Name (print) Date

_____
Signature

informed consent

Your Treatment Plan
Following a comprehensive dental examination and review of diagnostic information, a customized treatment plan will be developed for you. Included in this plan will be information about your current oral health, any treatment recommended to improve the function and health of your teeth and gums, and elective procedures available to enhance the cosmetics of your smile. We will take the time to thoroughly explain the conditions or diseases which may be present, as well as the procedures to address your dental needs and achieve the goals you have set for your smile. It should be noted that treatment is recommended based on the information we have gathered and to the best of the dentist's abilities. It is possible, however, for circumstances to arise during the course of treatment which would change the nature of the proposed treatment plan.

Custom Preparation
Every person comes with a unique set of circumstances which will determine the amount of tooth preparation required to achieve desired results. Some of these circumstances may not present themselves until the procedure begins (i.e. decay hidden under old crowns or fillings, etc.). The exact amount of enamel reduction will depend on various factors including, but not limited to, tooth size and position, previous dental restorations, decay, fractures, spaces, and the desired look and function of the final restoration. The dentist will exercise his professional judgement to plan and perform a conservative preparation of your teeth, and to make decisions regarding the means, manner, and method of any procedures as they deem appropriate for achieving the goals of your treatment plan.

Specific Results Not Guaranteed
We have enjoyed a very high degree of success with the procedures provided, and we are proud to know literally hundreds of clients who are pleased with the treatment provided under our care. Because human tissues react differently to dental treatment depending on a variety of factors, each individual restorative case is unique and final results are practically impossible to predict.

It is important to understand that even natural teeth are not perfect and that certain contours, color variations, and nuances are purposefully and artistically included in the porcelain restorations in order to create a very realistic replica of natural teeth. As with any artistic endeavor, aesthetics is a highly subjective perception. We appreciate the high degree of trust and confidence you have placed in us by selecting our office to provide your dental treatment. Once the final restorations are approved and permanently placed, any aesthetic issues will be addressed at our discretion and at our current fees.

Non-treatment option
You always have the option to elect no treatment. This alternative may entail a number of potential risks, some of which are difficult or impossible to quantify or predict. Some risks of non-treatment may include, but are not limited to: deterioration of the aesthetics and/or function of your teeth, improper biting or chewing, fracturing of your teeth, head or neck pain, additional wear of your teeth, abscesses or infection, pain, tooth sensitivity, tooth loss, or worsening periodontal condition.

Treatment risks
As with any dental treatment, certain potential risks and inconveniences can result from the proposed treatment. These risks can vary based on individual circumstances and variations in teeth and gums. Some of these situations can exist for a short time, while others could potentially extend for an unpredictable length of time. They include, but are not limited to: swelling, pain, tooth sensitivity, bleeding, bruising, discoloration, abscesses, numbness, mouth ulcers, changes in occlusion, endodontic therapy (root canal), chipping or loosening of temporary restorations, allergic reactions, jaw pain, and fractured enamel.

Risk factors which could affect the stability and longevity of your restorations
Due to the complex nature of the oral cavity and due to the nature of man-made dental materials and procedures, we will inform you of certain factors which could affect the lifespan of our dental restorations. In the event that your dental restorations do fail as a result of one of these risk factors, we will be happy to replace them at our full current fee.

Maintenance obligations
For successful results and to lessen the chances of complication, I hereby agree to comply with follow-up visits and excellent oral hygiene. In addition to post-operative visits to check bite details and verify tissue healing, 12 South Dental Studio will also make recommendations for your routine home-care and regular dental visits. I acknowledge that the diagnosis and treatment options have been explained to me. I have also been given the opportunity to read the preceding information and ask any questions, and those questions have been answered or explained to my satisfaction. By signing below, I agree to assume the risks and inconveniences of my treatment.

_____ _____
Signature Date

_____
Print Name