JOHN C. RADER, D.D.S., P.C.

123 North Henderson Avenue • Sevierville, Tennessee 37862
(865) 774-3320

PATIENT INFORMATION

(Please Print)

Patient Name _____ Date of Birth _____ Sex _____

Address _____ City/State _____ Zip _____

Home Phone _____ Cell # _____ School Name _____

Patient Lives With: ☐ Father ☐ Mother ☐ Both ☐ Other Email: _____

Father's Name _____ Phone _____ Cell _____ Date of Birth _____

Address _____ S.S.# _____

Occupation _____ Employer _____

Business Address _____ Business Phone _____

Dental Ins. Co. _____ Group # _____

Address _____ City/State _____ Zip _____

Mother's Name _____ Phone _____ Cell _____ Date of Birth _____

Address _____ S.S.# _____

Occupation _____ Employer _____

Business Address _____ Business Phone _____

Dental Ins. Co. _____ Group # _____

Address _____ City/State _____ Zip _____

Whom to Notify in Case of Emergency _____ Phone _____

Nearest Relative not Living with You _____ Phone _____

Address _____ City/State _____ Zip _____

Chief Dental Complaint _____

Former Dentist _____ Date of Last Dental Visit _____

Are You Active in any Organized or Recreational Sports Activities? _____

Are You interested in tooth whitening? _____

Whom May We Thank for Referring You? _____

(Please present dental insurance card to the receptionist)

Primary Dental Insurance _____ Subscriber's Name _____

Secondary Dental Insurance _____ Subscriber's Name _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. ***It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company.*** **In order to control cost of billing, we request that your copayment be paid at the conclusion of each visit.**

Insurance Authorization and Assignment

I hereby authorize John C. Rader, D.D.S., P.C. to furnish information to my insurance company concerning my dental condition and treatments and I hereby assign to the dentist all payments for dental services rendered to myself and for my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ Parent's Signature _____

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card

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Business Address _____ Business Phone _____

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Address _____ S.S.# _____

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HEALTH HISTORY

Name _____ Medical physician's name: _____

Date of last medical exam: _____ Phone: _____

Please answer each question. Check yes or no. If doubt, leave blank.

	YES	NO
1. Are you in good health now?	❑	❑
2. Are you now under the care of a physician?	❑	❑
If so, what is the condition being treated? _____		
3. Have you ever had any unusual effect from any previous dental treatment?	❑	❑
4. Have you ever had excessive bleeding following the extraction, or do cuts take longer to heal now than previously?	❑	❑
5. (Women) Are you pregnant? If so, give due date. _____		
6. Do you use tobacco in any form? If yes, how much? _____	❑	❑
7. Do you require pre-medicate with antibiotics before dental treatment?	❑	❑

8. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g., novocaine)	❑	❑	Aspirin	❑	❑
Barbiturates / sedatives / sleeping pills	❑	❑	Codeine	❑	❑
Penicillin	❑	❑	Sulfa drugs	❑	❑
Latex/Acrylic/Metal	❑	❑	Other allergies _____		

	YES	NO
9. Do you use controlled substances?	❑	❑
10. Are you taking medication at the present time? (List on page 3)	❑	❑
11. Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates?	❑	❑

12. Do you have or have you ever had the following?

Asthma/hay fever ❑ Yes ❑ No	Mitral valve prolapse/regurgitation ❑ Yes ❑ No	Cold Sores/Fever Blisters ❑ Yes ❑ No	Osteoporosis ❑ Yes ❑ No
Bronchitis ❑ Yes ❑ No	Artificial heart valve ❑ Yes ❑ No	Cortisone Medicine ❑ Yes ❑ No	Pain in Jaw Joints ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	Pacemaker ❑ Yes ❑ No	Drug Addiction ❑ Yes ❑ No	Radiation Treatments ❑ Yes ❑ No
Family history of diabetes ❑ Yes ❑ No	Kidney trouble ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	Recent Weight Loss ❑ Yes ❑ No
Allergies ❑ Yes ❑ No	Venereal disease/Herpes ❑ Yes ❑ No	Epilepsy or Seizures ❑ Yes ❑ No	Rheumatism ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No	Hip surgery ❑ Yes ❑ No	Excessive Bleeding ❑ Yes ❑ No	Scarlet Fever ❑ Yes ❑ No
HIV + Virus (AIDS) ❑ Yes ❑ No	Artificial joint/Date ❑ Yes ❑ No	Excessive Thirst ❑ Yes ❑ No	Shingles ❑ Yes ❑ No
Anemia ❑ Yes ❑ No	Orthodontics ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No	Sickle Cell Disease ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No	Are you taking oral contraceptives? ❑ Yes ❑ No	Hemophilia ❑ Yes ❑ No	Sinus Trouble ❑ Yes ❑ No
Heart trouble ❑ Yes ❑ No	Alzheimer's Disease ❑ Yes ❑ No	Hepatitis A ❑ Yes ❑ No	Spina Bifida ❑ Yes ❑ No
High blood pressure ❑ Yes ❑ No	Angina ❑ Yes ❑ No	Hepatitis B or C ❑ Yes ❑ No	Stomach/Intestinal Disease ❑ Yes ❑ No
Faint easily ❑ Yes ❑ No	Arthritis/Gout ❑ Yes ❑ No	High Cholesterol ❑ Yes ❑ No	Stroke ❑ Yes ❑ No
Frequent headaches ❑ Yes ❑ No	Blood Disease ❑ Yes ❑ No	Hives or Rash ❑ Yes ❑ No	Swelling of Limbs ❑ Yes ❑ No
Psychiatric treatment ❑ Yes ❑ No	Blood Transfusion ❑ Yes ❑ No	Hypoglycemia ❑ Yes ❑ No	Thyroid Disease ❑ Yes ❑ No
Head or Neck Injury ❑ Yes ❑ No	Breathing Problem ❑ Yes ❑ No	Leukemia ❑ Yes ❑ No	Tonsilitis ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No	Bruise Easily ❑ Yes ❑ No	Lupus ❑ Yes ❑ No	Tumors or Growth ❑ Yes ❑ No
Heart murmur/Irregular Beat ❑ Yes ❑ No	Cancer ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No	Ulcer ❑ Yes ❑ No
Heart attack / trouble ❑ Yes ❑ No	Chemotherapy ❑ Yes ❑ No	Low Blood Pressure ❑ Yes ❑ No	
Congenital heart disease ❑ Yes ❑ No	Chest Pains ❑ Yes ❑ No	Lung Disease ❑ Yes ❑ No	Other _____

13. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

14. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

15. Do you have or have you ever had any of the following?

MOUTH	YES	NO	TEETH	YES	NO
Bleeding, sore gums	❑	❑	Loose teeth	❑	❑
Unpleasant taste/bad breath	❑	❑	Sensitive to hot / cold / sweets	❑	❑
Swelling / lumps in mouth	❑	❑	Sensitive to biting	❑	❑
Clicking / popping jaw	❑	❑	Food impaction	❑	❑
Difficulty opening or closing jaw	❑	❑	Clenching / grinding	❑	❑
Change in bite	❑	❑	Shifting of teeth	❑	❑

16. For your dental treatment would you prefer:

_____ Local anesthetic (injections) _____ Nitrous oxide (gas) _____ Both _____ Nothing

I give my consent to radiographic examination (x-rays) for the purpose of dental diagnosis. I give my consent to use local anesthesia, nitrous oxide analgesia, and relaxants for the purpose of having the necessary dental treatment completed. I understand that I am responsible for all costs of dental treatment. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or medication, I will inform the dentist at the next appointment.

Signature _____ Date _____

patient signature

John C. Rader, D.D.S., P.C.

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Sevierville, TN 37862
Telephone: (865) 774-3320
Fax: (865) 774-2126
Email: drrader@seviervilledentist.com

PATIENT NAME_____DATE: _____

PLEASE LIST ALL MEDICATIONS TAKEN AND WHAT MEDICAL CONDITION THEY ARE TAKEN FOR.

MEDICATION	MEDICAL CONDITION

John C. Rader,D.D.S., P.C.

COMMUNICATION OF PRIVATE HEALTH INFORMATION FORM

HIPAA Privacy Rule gives you the patient the right to request restriction on uses and disclosures of your Protected Health Information (PHI). You also have the right to request confidential communications or that communications of PHI be made by alternative means, such as sending correspondence to an alternate address or call a different phone number than what is listed.

Home Phone #_____

- ❏ O.K. to leave message with detailed information
- ❏ Leave message with call back number only
- ❏ You may leave a detailed message with anyone that may answer at my residence
- ❏ Please only leave message with _____

Contact Person Name Relationship

Work Telephone #_____

- ❏ O.K. to leave message with detailed information
- ❏ Leave message with call back number only
- ❏ Other_____

Written Communications

- ❏ O.K. to mail to my home address
- ❏ O.K. to mail to my work/office address
- ❏ O.K. to fax to this number _____

Insurance

- ❏ O.K. to file claims
- ❏ O.K. to discuss coverage/benefits with insurance companies

I _____ give John C. Rader D.D.S., P.C. permission to disclose my health information and account information to:
Please list all parties we may discuss this information with (spouse, other family members, etc.) please give full names.

_____

_____

_____

*Patient/Parent Signature*_____ *Date* _____

*Print Name*_____ *Birth Date*_____

John C. Rader, D.D.S., P.C.
Family Dentistry

PATIENT FINANCIAL LIABILITY FORM

In our continued efforts to provide you with the best dental care possible at reasonable rates, we are pleased to offer the following methods of payment:

1. **Cash, Check or Money Order**
2. **Visa, MasterCard or Discover**
3. **Extended payment plan through the CareCredit finance company, with prior credit approval.**

Full payment of your account/bill is considered part of your treatment, and is required at the time services are rendered. Returned checks are subject to additional service fees. If your check has been returned for insufficient funds, you will be required to pay in cash, credit card or money order at future appointments.

All unpaid accounts past ninety (90) days are subject to a 2.25% finance charge, assessed monthly on the remaining balance. **Should Collections be necessary, 40% of the balance will be added to your account, in addition to the Collection Agency fees.** Should legal action also be necessary to collect on your account, you agree to pay attorney's fees and court costs incurred for collection.

INSURANCE POLICY

We are happy to file claims and accept assignment of insurance benefits from ALL insurance companies (excluding TennCare). However, **we are only a provider with Delta Dental.** Co-pays, deductibles and co-insurance amounts are due at the time of treatment. **Insurance is a contract between you, your insurance company and your employer. It is your responsibility to know what your insurance does and does not cover.** If your insurance company does not pay the balance of your bill within 90 days, the amount will be billed to you; payment due upon receipt. You will be required to pursue reimbursement from your insurance company. You are fully responsible for all costs not covered by your insurance plan. If you have any questions regarding your bill, please call our office.

PATIENT NO SHOW POLICY

There will be a minimum of $45 applied to your account for not showing for an appointment, if you fail to provide notice on a business day (when the office is open) at least twenty-four (24) hours before the appointment. **Although we provide courtesy reminder calls in advance, you are ultimately responsible for remembering your appointment date and time.**

***" I have read the above information and agree to the terms contained** therein."*[1]

Patient/Parent's PRINTED Name Social Security Number

Patient's/Parent's SIGNATURE Date

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