New Patient Information

Last Name	Date
First Name	Preferred Name
Date of Birth	Address
Social Security No:	City State Zip
Best Phone Number to Reach you:	Secondary Phone Number:

Sex: Male Female	Email Address:
Marital Status:	Spouse/Partner Name:
Person Financially Responsible for this Account (if not Yourself):	Phone:
Your Occupation:	Your Employer:
Business Address:	Business Phone:

Is another member of your family a patient here?	Referred to Us By:
Name of family who is patient here:	How did you hear about us:
Emergency Contact:	Emergency Contact Phone:
Emergency Contact (2):	Emergency Contact Phone(2):

Dental Insurance information

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company	Insurance Company
Employer:	Employer:
Subscriber ID#:	Subscriber ID#:
Group No:	Group No:
Employee/Policy Carrier	Employee/Policy Carrier
Employee DOB:	Employee DOB:
Employee SS#:	Employee SS#:

Assignment & Release

I, _____, certify that I or my dependant(s) have the insurance coverage with the company listed. I assign directly to Knoxville Dental Group/Newman Family Dentistry/Dr. Kathyrn Newman, DDS, all insurance benefits, if any, otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges if insurance denies payment for any reason.

I also authorize Newman Family Dentistry/Knoxville Dental Group/Dr. Kathryn Newman, DDS to disclose my healthcare information to above named insurance companies and their agents for the purpose of obtaining payment for services rendered and determining dental benefits.

_____ _____

Date Signature

General Consent For Dental Treatment

I understand the purpose of this general consent is to raise my awareness of risks that are common in many dental procedures. I understand my dentist reserves the right where appropriate to provide me with a more specific informed consent discussion.

I agree to examination by the dentist and staff. I agree to basic treatment such as x-rays, dental cleanings, dental injections, fillings, and pain management. I consent to the administration of any emergency drugs and treatment should an emergency situation arise and I am unable to verbally communicate and consent for emergency treatment.

I understand that every dental patient has the right to informed consent. That means that as the patient or as a legal guardian for the patient, I should understand what treatment is being proposed, what the possible complications and risks are and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, which carries its own risks. My signature below confirms that I understand that no dental treatment is completely risk free, and my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur.

For routine fillings, dental cleanings, prescriptions of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, pressure sensitivity, pain, infection, unusual reaction/allergy to medications given or prescribed. I understand that medications prescribed have common side effects that are listed by the manufacturer. By signing below, I agree to read all drug information distributed by the pharmacist, should a prescription be prescribed. Further, if I am taking other medications, I understand that my dental medications could have adverse interactions. I agree to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements and over-the counter medications.

For the administration of local anesthetic, I understand that for many treatments and procedures, I will be given a local anesthetic injection and that in a certain percentage of cases, patients have had an allergic or adverse reaction to the anesthetic, or temporary or permanent injury to the nerves and or blood vessels from the injection. For oral surgery, I understand that there is always a risk of post-operative infection, nerve damage, and iatrogenic injury (unintentional injury due to treatment). In rare cases, complications from surgery can be permanent, disabling, or even in extremely rare cases, cause death.

I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment. I understand that even simple procedures may result in temporary discomfort in the gums or teeth. I understand that all procedures carry the risk of possible aspiration of small objects during or after treatment. I agree to contact my dentist immediately or go to the nearest emergency room should this happen after leaving the dental office.

I understand that my dentist agrees to offer me appropriate dental care at all times to the best of her ability, however, I also understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurances as to the outcomes or results of treatment.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications, and I will ask questions if for any reason I feel I am not fully informed about my procedure, the risks or the alternatives to the procedure.

_____ _____

Date Signature

This consent will stand indefinitely unless the dentist-patient is terminated or you request it be discontinued in writing directly to our office either in person or via certified mail.

Patient Name:	Patient No:

Dental History – **Please answer the following questions to the best of your ability. Circle "Y" to answer "yes" or "N" to answer "no".**

Date of Last Dental Exam:	Date of Last Dental Cleaning:
Previous Dentist Name:	City and State of Previous Dentist?
How often do you floss your teeth?	How often do you brush your teeth?

Are you having any dental problems now?.....**Y N**	What type of dental problem(s) are you having?

Do your gums bleed when you brush or floss?.....**Y N**	Have you ever been told you have periodontal (gum) disease?.....**Y N**

Do you have issues with any of the following conditions?	Do you have pain in your jaw (TMJ) area?.....**Y N**
Bad Breath?.....**Y N**	If yes, how often?
Tooth Sensitivity?.....**Y N**	_____
Sensitive teeth after having fillings done?.....**Y N**	Does your jaw make noises when you open your mouth or chew?.....**Y N**
Mouth Ulcers?.....**Y N**	Do you clench your teeth?.....**Y N**
Dry Mouth?.....**Y N**	Do you grind your teeth?.....**Y N**
Do you wear dentures or paritals?.....**Y N**	Have you had a serious injury to your face/mouth?.....**Y N**
Do you like the way your teeth look now?.....**Y N**	If so, please describe _____

Have you previously seen any dental specialists?.....**Y N**	Do you have any ***dental*** conditions or information not listed above that you want us to know about?
Endodontist (root canals)?.....**Y N**	
Oral Surgeon?.....**Y N**	
Orthodontist (braces)?.....**Y N**	
Periodontist (gums)?.....**Y N**	

Have you ever had an ***upsetting*** experience in a dental office before?.....**Y N** If so, please explain what happened:	Is there anything we can do to make your dental visits easier or less stressful?

Medical Health History

Are you currently under the care of a general doctor?.....**Y N**	Name of Primary Care Doctor:
Are you in general good health?.....**Y N**	Pharmacy Name & Phone:
Have you been hospitalized in the past 5 years?.....**Y N**	Have you had any surgical procedures in the past 2 years?.....**Y N**
If so, for what condition(s):	If so, what type of procedure(s)?

Are you ALLERGIC to any of the following? (If yes, please describe the type of reaction you had on the line beside the substance (i.e. hives, anaphylaxis, rash, itching, trouble breathing, vomiting, etc).

-Local anesthetics…**Y N** _____ -Aspirin…..**Y N** _____
-Penicillin/Amoxicillin….**Y N** _____ -Metals…..**Y N** _____
-Sulfa Drugs…..**Y N** _____ -Latex…….**Y N** _____
-Codeine or other narcotics…**Y N** _____ -Other antibiotics…….**Y N** _(List them below)_____
-Nuts….**Y N** _____ -Milk Casein…….**Y N** _____

Are you **ALLERGIC to any medications**? Please list below.	List any other **known allergies** below.

List **ALL MEDICATIONS** you are **taking** (including over-the-counter medications, herbal supplements) and include dosage. (Please attach list if necessary)

Have you ever had a **JOINT REPLACEMENT**?.....Y N	Date of Joint Replacement?	Any complications with Joint Replacement?

Have you ever **taken bisphosphonates** or other medications for osteoporosis, bone pain or Paget's Disease (Reclast, Boniva, Fosamax, Zometa, etc).....**Y N**	Do you use illicit drugs? .....**Y N** Do you consume alcohol?.....**Y N** Do you consume more than 3 alcoholic drinks per week? **Y N**

WOMEN ONLY:

Are you or could you possibly be pregnant?.....**Y** N If yes, how far along are you in your pregnancy?_____

Are you taking oral contraceptives (birth control pills)?.....**Y N** Are you breastfeeding?.....**Y N**

Please answer the following by circling "Y" for yes, "N" for No, or "?" for Unknown. It is important you answer every question.

Artificial (Prosthetic Heart Valve)..... Y N ?	Previous Infective Endocarditis.....Y N ?
Heart Transplant Complications.....Y N ?	Scarlet Fever.....Y N ?
Heart Disease.....Y N ?	High Blood Pressure.....Y N ?
Stroke .....Y N ?	Heart Murmur.....Y N ?
Mitral Valve Prolapse.....Y N ?	Do you have a pacemaker.....Y N ?
Ankle Swelling.....Y N ?	Chest pain upon exertion.....Y N ?
Low Blood Pressure.....Y N ?	Anemia.....Y N ?
Fainting or Dizzy Spells.....Y N ?	Asthma.....Y N ?
COPD.....Y N ?	HIV/AIDS.....Y N ?
Tuberculosis.....Y N ?	Chemotherapy treatment.....Y N ?
Venereal Disease (Syphilis, Gonorrhea, Etc.) .....Y N ?	Bruise Easily.....Y N ?
History of Cancer.....Y N ? Type:	Hepatitis.....Y N ? Circle Type: A B C D E
Radiation Therapy.....Y N ?	Radiation to head/neck.....Y N ?
Psychiatric Treatment.....Y N ?	Difficulty Swallowing.....Y N ?
Excessive Bleeding.....Y N ?	Taking Aspirin.....Y N ?
Arthritis.....Y N ?	Kidney Disease.....Y N ?
Gall Bladder Disease.....Y N ?	Epilepsy/Seizures.....Y N ?
Thyroid Disease.....Y N ?	Had Weight Loss Surgery.....Y N ?
Acid Reflux/GERD.....Y N ?	Osteoporosis.....Y N ?
Rheumatic Fever.....Y N ?	Dry Mouth.....Y N ?
Take medication for ADHD/ADD.....Y N ?	Cataracts/Glaucoma.....Y N ?
Frequent Headaches.....Y N ?	Migraines.....Y N ?
Sleep Disorder.....Y N ?	Snoring.....Y N ?
Clenching/Grinding your Teeth.....Y N ?	High Stress.....Y N ?
Bladder Disease.....Y N ?	Diabetes (Type 1) .....Y N ?
Diabetes (Type 2) .....Y N ?	Herpes (HSV1/HSV2) .....Y N ?
Gout.....Y N ?	Alzheimer's Disease.....Y N ?
Dementia.....Y N ?	Memory Problems.....Y N ?
Blood Transfusions.....Y N ?	Cold Sores/Fever Blisters.....Y N ?
High Cholesterol.....Y N ?	A-Fib/Irregular Heart Rhythm.....Y N ?
Liver Disease.....Y N ?	Leukemia.....Y N ?
Dialysis.....Y N ?	Shingles.....Y N ?
Sinus Problems.....Y N ?	Disease of Bones.....Y N ?
Tonsilitis.....Y N ?	Addiction to Drugs.....Y N ?
Addiction to Alcohol.....Y N ?	Stomach/GI Problems.....Y N ?
Chronic Cough.....Y N ?	Blood Clotting Disorder.....Y N ?
Nervous Disorders.....Y N ?	Neck/Back Injury.....Y N ?

Do you have any additional medical issues not listed above? Please describe here: