Patient Name:________________________________ Date: ________________________

HEALTH HISTORY

Physician's Name _______________________________ Phone # _________________________ Date of last physical _______________

Place a mark on "yes" or "no" to

AIDS/HIV	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tuberculosis	❑Yes	❑No
ANEMIA	❑Yes	❑No	Heart Problems	❑Yes	❑No	Tumor or growth on head/neck	❑Yes	❑No
Arthritis, Rheumatism	❑Yes	❑No	Hepatitis Type ________	❑Yes	❑No	Ulcer	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Headaches	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Asthma	❑Yes	❑No	Liver Disease	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Bleeding abnormally	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Limited Opening	❑Yes	❑No
Blood Disease	❑Yes	❑No	Nervous Problems	❑Yes	❑No	Congested Ears	❑Yes	❑No
Cancer	❑Yes	❑No	Pacemaker	❑Yes	❑No	Dizziness	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Posture Problems	❑Yes	❑No
Heart Lesions	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Clenching	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Grinding	❑Yes	❑No
Cough, persistent	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Facial Pain	❑Yes	❑No
Diabetes	❑Yes	❑No	Stroke	❑Yes	❑No	Neck Ache	❑Yes	❑No
Epilepsy	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Bell's palsy	❑Yes	❑No
Fainting or dizziness	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No			
Glaucoma	❑Yes	❑No	Thyroid Problems	❑Yes	❑No			
			Tonsillitis	❑Yes	❑No			

Do you use tobacco products?
❑Yes ❑No If yes, what and how often, how long

____

Do you use antidepressants or sleeping pills?
❑Yes ❑No if yes, list name(s)

____

Do you or your Spouse have the following?

Sleep Apnea ❑Yes ❑No Do you Snore? ❑Yes ❑No

Have you had sleep studies? ❑Yes ❑No

(CPAP) ❑Yes ❑No Do you use your CPAP? ❑Yes ❑No

____

Are you on any blood thinners, including aspirin?
❑Yes mg _____ ❑No

Have you ever seen an ENT (ear, nose and throat doctor)?
❑Yes ❑No Name: ___________________________

Have you seen a chiropractor?
❑Yes ❑No Name: ___________________________

Have you seen a neurologist?
❑Yes ❑No Name: ___________________________

Have you had braces?
❑Yes ❑No Name: ___________________________

Do you have massage therapy regularly?
❑Yes ❑No Name: ___________________________

Are you pregnant? ❑Yes ❑No

If yes when is your due date? ______________________

Taking birth control pills? ❑Yes ❑No

Are you taking hormones? ❑Yes ❑No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis_________________________________

____

____

❑Vitamins/Minerals ❑Herbs

Pharmacy Name ____________________________

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ None
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other______

2 DENTAL INTERVIEW

Choto Family Dentistry is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability……thank you!

- What is the main purpose of your first visit and what would you like to get accomplished? ______________________

____

- Briefly mention any positive or negative aspects of your previous dental visits: ______________________

____

- What do you already know about our office and what are your expectations? ______________________

____

Treatment Recommendations or **Treatment Options?**

Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you…… please rate on the following scale from 10 to 1.

1. How (dental) healthy would you like to be?

←---→

10 (healthiest) 1(not a concern at this time)

2. Almost all dental problems are predictable and preventable….in order to not overwhelm you with excess details, How preventive (or proactive) would you like to be regarding dental disease?

←---→

10 ("nip it in the bud early") 1(wait until it hurts)

3. How important are dental cosmetics to you?

←---→

10 (very important) 1(not important)

Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.
How important is facial cosmetics to you?

←---→

10 (very important) 1(not important)

Anything else you would like to mention? ____

NEW PATIENT MENU OF SERVICES

Our office offers a diverse array of dental services. To help us better understand your needs and desires please check which of the following services in which you are interested.

Cosmetic Services

- ❑ Smile Makeover
- ❑ Porcelain Veneers
- ❑ Full Mouth Rejuvenation
- ❑ Replacing Old Fillings
- ❑ Cosmetic Dentures
- ❑ Teeth Whitening

Discomfort / Pain

- ❑ Tooth Pain Relief
- ❑ Jaw Pain Relief
- ❑ Chronic Headache Treatment
- ❑ Migraine Treatment

Specialized Services

- ❑ Sedation Dentistry
- ❑ Dental Implant
- ❑ Myofunctional Therapy (Oral Habit Therapy)

Examination Services

- ❑ Comprehensive Examination
- ❑ Personalized Lifetime Dental Plan
- ❑ Teeth Cleaning & Maintenance

Consultative Services

Consultation about: ____

2nd Opinion about: ____

4 PATIENT INFORMATION

Date ______

Patient Name ______

Wished to be called ______

Social Security # ______

Address ______

City ______ State ______ Zip ______

Sex ❑ M ❑ F Birth date ______ Age ______

❑ Married ❑ Widowed ❑ Single

Employer ______

Occupation ______

Employer Address ______

______

Employer Phone ______

Spouse's Name ______

How did you hear about our office?

______

5 INSURANCE INFORMATION

Subscriber's Name ______

Subscriber's Birth Date ______

Subscriber's ID or SSN ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ID# ______

Is there any additional dental insurance? ______

Subscriber's Name ______

Subscriber's Birth Date ______

Subscriber's ID or SSN ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ID# ______

Is Patient covered by medical insurance? ______

Subscriber's Name ______

Subscriber's Birth Date ______

Subscriber's ID or SSN ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ID# ______

ASSIGNMENT AND RELEASE

I understand that Choto Family Dentistry participates with multiple dental insurance companies and does not participate with all insurance companies, but will accept the payment from my insurance company towards the dental services that are needed to obtain a healthy mouth. Choto Family Dentistry may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

______
Signature of Patient, Parent, Guardian or Personal Representative

______ Date

______ Relationship to Patient

6 CONTACT INFORMATION

Home ( ) ______

Cell Phone ( ) ______
Used for confirming appointments

Work ( ) ______

E-mail Address ______
Used for confirming appointments

IN CASE OF AN EMERGENCY

Name ______ Relationship ______

Home ( ) ______ Work Phone ( ) ______ Cell Phone ( ) ______

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____ Email: ____

Address: ______________________________________ SSN: ____

____

Telephone: ___________________________________

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply lo any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:
Choto Family Dentistry

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________**,** have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature: ____ Date: __________________

If this Consent is signed by a personal representative on behalf of the patient complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: __________________

1624 Choto Markets Way, Knoxville, TN 37822 | (865) 409-5077 | info@chotofamilydentistry.com

Office Policies

We are honored that you have chosen Choto Family Dentistry as your dental provider. We are constantly staying up on the leading technology and re-investing in our practice so we can deliver top notch, gentle, compassionate care. As our patient, our doctors and staff will diagnose and treat with the fullest intent of the absolute best and gentle care possible. At no time will we diagnose and treat our patients limiting ourselves under the guidelines of the insurance coverage. That being said, we will strive to get the maximum insurance payment for you when treatment is needed.

_______ **X-Rays**

Our office is equipped with the latest, state of the art, safe technology in digital dental radiographs. We will update any necessary x-rays, including *Panorex* (that are less than 3 years old) and *Bitewings* (less than I year old). If you are a new patient, it is your responsibility to make sure we have any current x-rays in time for your first appointment. Please be sure to call your previous dental care provider or other providers that may have any x-rays and have them sent to us. Our email is listed above. If we do not have current x-rays, we will take them in our office in order to have a complete exam. Insurance may or may not pay for these. We do not allow your insurance to dictate the care that you deserve and the care that we provide. Current x-rays are vital for Choto Family Dentistry to do a complete exam in order to provide the top quality care.

_______ **Medicine**

If you need to premedicate for any reason, or if you are on any type of blood thinner, please let us know in advance of your appointment. We can kindly remind you to take your premedication prior to your scheduled appointment time if we need to. However, it is your responsibility to make sure you are premedicated. If you arrive for your appointment and you have not premedicated, and the doctor is unable to complete your appointment, you may be charged an office visit. It is very important that Choto Family Dentistry know all medicines that you are taking, please list all of them.

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_______ **Appointments**

Your scheduled appointment time has been reserved specifically for you. We request a 2 business day notice if you need to cancel your appointment. If you fail to make your appointment or do not give us a 48-hour cancellation notice, you may be charged an office visit. We are aware that unforeseen events sometimes require missing an appointment. Repeatedly broken or failed appointments may result in dismissing services as your provider.

_______ **Insurance**

Choto Family Dentistry are both providers for multiple insurance plans. It is the patient's responsibility to know and understand your plan's benefits. We will file your insurance as a courtesy, but expect your portion to be paid in full at the date of the service. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to complexities of insurance contracts. If you need to know exactly what is covered and what is not, you will need to call your insurance company. We are a provider for many plans but will file all insurance claims at the courtesy of you, our patient. It is impossible to research all of the details of all these plans because they are currently changing. Please do your diligence.

_______ **Payment**

Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for service and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. At that time, a finance charge will start to accrue each month on any past due balance. If you have any questions, our courteous staff is always available to answer them. In the event your account should be sent to a collection agency for failure to pay, you will be responsible for any and all collection charges and attorney fees.

Payment is expected at time of service. If special financial arrangements are needed, an extended payment plan is available through Care Credit. Choto Family Dentistry offers no interest plans through Care Credit for up to 12 months.

More information about this plan is available at www.carecredit.com

If you have read and understand Choto Family Dentistry's paperwork and the policies of our office, please initial each policy. sign and date this page. Again, thank you for allowing us to take care of your dental needs. Feel free to let anyone in our office know if you have any questions or concerns or call us at (865) 409-5077.

Signature: ______________________________________ Date: ________________