

## New Patient Registration

Patient Name: \_\_\_\_\_ LastName: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Patient is: ☐ Policy Holder  
Preferred Name: \_\_\_\_\_ ☐ Responsible Party

Responsible Party Name (if other than the patient) First: \_\_\_\_\_ Last: \_\_\_\_\_  
Is Responsible Party's address the same as the Patient? ☐ Yes ☐ No (If no, please provide on the back of form)

### Patient Information:

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we contact you via? Text ☐ Email ☐ Both ☐

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. \_\_\_\_\_ Drivers. Lic: \_\_\_\_\_

### Insurance Information:

Name of Insured: \_\_\_\_\_ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other \_\_\_\_\_

Insured Soc. Sec. \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

### Dental Questionnaire:

Date of last Dental Exam: \_\_\_\_\_ Date of last Dental Cleaning: \_\_\_\_\_

Are you experiencing any pain or sensitivity with any of your teeth? \_\_\_\_\_ If yes, for how long?: \_\_\_\_\_

Have you tried anything to help with the pain/sensitivity?: \_\_\_\_\_ If yes, how is it working?: \_\_\_\_\_

Are you having any specific dental concerns today? \_\_\_\_\_

Is there anything specific you would like us to focus on today?: \_\_\_\_\_

On a scale of 1-10, with 10 being the best, how would you rate your overall smile and condition of your teeth?: \_\_\_\_\_  
What would you like them to be?: \_\_\_\_\_

Please circle if you have had any of the following:

Bad Breathe	• Food collection in between teeth	Sensitivity to sweets
Bleeding gums	Grinding of teeth	Orthodontic treatment
Blisters on gums or lips	Gums swollen or tender	Periodontal treatment
Burning sensation with tongue	Loose teeth	Gum surgery
Chewing on fingernails or objects	Broken fillings	How often do you brush? _____
Clicking or popping in your jaw	Sensitivity to cold	How often do you floss? _____
Dry Mouth	Sensitivity to hot	

Emergency contact person: Name: \_\_\_\_\_ phone number \_\_\_\_\_

Who may we thank for your referral? \_\_\_\_\_

MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
 Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
 Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
 Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_  
 Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No \_\_\_\_\_  
 Are you on a special diet? ☐ Yes ☐ No \_\_\_\_\_  
 Do you use tobacco? ☐ Yes ☐ No \_\_\_\_\_  
 Do you use controlled substances? ☐ Yes ☐ No \_\_\_\_\_

Women: Are you

 Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics  
☐ Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

 Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Back To Basics Dental Center, L.L.C.

## D.B.A. Back 2 Basics Dentistry

*Your Privacy Is Important to Us*

### Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Back 2 Basics Dentistry. I hereby authorize, as indicated by my signature below, Back 2 Basics Dentistry, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

#### Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number \_\_\_\_\_
- ☐ You may contact me on my mobile telephone number \_\_\_\_\_
- ☐ You may contact me on my work telephone number \_\_\_\_\_
- ☐ You may send me an email at: \_\_\_\_\_
- ☐ Other \_\_\_\_\_

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_
4. \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_

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#### For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign \_\_\_\_\_
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) \_\_\_\_\_

Staff Person Initials \_\_\_\_\_

## PATIENT CONSENT

### Clinical

1. I authorize **BACK TO BASICS DENTAL CENTER, L.L.C.**, to perform all recommended treatment.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

### Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.8% MPR will be automatically tabulated into my account if my balance is 30 days old or older. I will also have a \$2.00 per month billing charge of \$2.00. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
5. A \$40 per hour missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

### Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

**I have read this Patient Consent and agree to all terms and conditions herein.**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a child, please provide the parental or legal guardian's consent:

**NOTE (MINORS):** The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.

**Back 2 Basics Dentistry**  
**Acknowledgement of Office Policies**

\_\_\_\_\_ I hereby authorize the release of any information necessary to process an insurance claim and request direct payment to Back to Basics Dental Center.

\_\_\_\_\_ Fees are to be paid at the time the services are performed.

\_\_\_\_\_ It is my responsibility to understand my dental insurance. Back 2 Basics Dentistry is only given an estimate of my coverage through my insurance company. I am responsible for any balance my insurance does not pay.

\_\_\_\_\_ Our dentists base treatment recommendations on your needs, not what your insurance covers.

\_\_\_\_\_ If I require a procedure that requires two or more hours I will be asked to put a deposit of \$100.00 that will go towards my dental procedure.

\_\_\_\_\_ Based on Tennessee state law children under the age of 18 must be accompanied by a parent or legal guardian to ALL dental appointments.

\_\_\_\_\_ I understand that children should not be brought with an adult when the adult has the scheduled appointment. It is not in the best interest of the child, the adult patient, nor our staff.

\_\_\_\_\_ I understand that if I am over 18 years old any issues regarding my treatment and or my account cannot be discussed with family members or friends unless I specify in writing. All other communications will be in accordance with the HIPAA guidelines. (Please ask the front desk patient coordinator for more information if you wish to add your spouse or family member)

\_\_\_\_\_ Under normal circumstances dental work completed in our office is guaranteed for one year providing that I take appropriate care of my mouth, received regular six month check ups and have regular cleanings.

\_\_\_\_\_ I understand that my dental record information belongs to me but my dental records, radiographs, photos, and study models are the property of Back to Basics Dental Center, LLC. If I request dental records, I am aware there will be a standard fee of \$20 for these records.

\_\_\_\_\_ I understand that if a check written for my account to Back to Basics Dental Center is returned for insufficient funds, a returned check fee of \$30.00 will be added to the original balance of my check and I am responsible for paying this amount prior to any further dental appointments.

\_\_\_\_\_ I understand that should my account balance not be paid in a timely manner, it will be turned over to our collection agency. I will be responsible for any billing, finance, legal or collection fees, which may occur.

\_\_\_\_\_ I understand that I may be charged \$40.00 for appointments cancelled with less than 24 hours notice prior to my next visit except in case of emergencies or serious illness. I understand that I will not be given any other dental appointments until this balance is paid. I further understand that my insurance company will not pay for this charge.

\_\_\_\_\_ I understand that if I miss three (3) appointments without 24 hours notice of cancellation, I may be discharged from the practice.

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date of signature \_\_\_\_\_

Back 2 Basics Dentistry  
1762 Hwy 48  
Clarksville, Tn 37040  
931-645-8000

Photo and Video Release

Date: \_\_\_\_\_

Name: \_\_\_\_\_

I hereby

- ☐ Authorize
- ☐ Do not authorize

the use and reproduction by Back 2 Basics Dental Center, LLC, DBA Back 2 Basics Dentistry, of any and all photographs and/or videos which have been taken of me without further compensation to me. All negatives, positives, digital files, etc. shall constitute property of Back 2 Basics Dentistry solely and completely.

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Signature