Christian A. Clinard, DDS

Patient Information

First Name:_____Middle Initial:_____Last Name:_____ ☐ Male ☐ Female

Preferred Name:_____ Birth Date: _____Social Security:_____

Address:_____City/St:_____Zip:_____

Home Phone: _____Work Phone: _____Mobile Phone:_____

Marital Status: ☐ Married ☐ Single Email:_____

Emergency Contact: Name:_____ Phone Number: _____

Responsible Party (Parent/Guardian if under 18):

Name:_____ Birth Date: _____Social Security:_____

Address:_____ City/St:_____Zip:_____

Home Phone: _____Work Phone: _____Mobile Phone:_____

Primary Dental Insurance Information

Insurance: _____

Employer:_____

If someone other than patient:

Name of Policyholder:_____

Social Security: _____DOB:_____

Secondary Dental Insurance Information

Insurance: _____

Employer:_____

Name of Policyholder:_____

Social Security: _____DOB:_____

Office Policies

If you must cancel an appointment, we would appreciate at least a 24 hour notice. There will be a cancellation fee charged for "No Shows" and cancellations without proper notice.

Payment is expected at the time of treatment. If you have insurance, you are responsible for whatever the insurance company does not pay. If we are unable to resolve any problems with the insurance company, the balance is ultimately the patient's responsibility. Accounts 60+ days overdue are subject to a service charge ranging from $5-25 a month until balance is paid in full. The service charge is dependent on the balance due.

I authorize dental treatment of the person named herein and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself & members of my family shown by statements, promptly upon presentation thereof. In the event my account is turned over to collections, I/we agree to pay any costs associated with the collection of the patient balance(s). If legal action is necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay ALL collection fees, reasonable attorney's fees or other such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of said claim(s).

Signature:_____Date:_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Anesthetics ☐ Latex ☐ Acrylic ☐ Metals

☐ Other: If yes, please list: _____

Do you use Tobacco/Smoke/Vape? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Please check all that apply to your past or present health:

☐ ADHD	☐ COPD	☐ HPV	☐ Seizures
☐ Alzheimer's Disease	☐ CPAP	☐ Kidney Disease	☐ Sensory Disorder
☐ Arthritis	☐ Diabetes	☐ Liver Disease	☐ Stroke
☐ Artificial Joint (s)	☐ Drug Addiction	☐ Low Blood Pressure	☐ Thyroid Problem
☐ Asthma	☐ Epilepsy	☐ Mental Disorders	☐ Tuberculosis
☐ Autism	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Other (explain)
☐ Behavioral Disorder	☐ Hepatitis A,B,C	☐ Neurological Disorder	
☐ Blood Clotting Disorder	☐ Herpes or Active Blisters	☐ Pacemaker/Defibrillator	
☐ Cancer/Malignancies	☐ High Blood Pressure	☐ Pre-Medicate	
☐ Chemotherapy	☐ HIV	☐ Radiation Treatment	

List of current medicines:

_____

_____

_____

Physician's name:_____ Previous dentist:_____ Date of last dental exam:_____

Please read each statement and sign below:

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 health. It is my responsibility to inform this office of any changes.

We require that ALL patients have an exam by Dr. Clinard **NO LESS** than once a year and x-rays **AT LEAST** every two years. I agree to this office policy for exam and x-rays.

Phone calls, mail, text messaging and encrypted e-mail may be used to communicate medical, billing or appointment information. I agree to these forms of communication.

Signature:_____ Date:_____

Christian A Clinard DDS
FAMILY DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgment

I have been given/offered a copy of Christian A. Clinard Family Dentistry's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Christian A. Clinard Family Dentistry has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at Dr. Christian Clinard's office at 865-777-2949.

My signature below acknowledges that I have been provided/offered a copy of the Notice of Privacy Practices:

_____

Print Patient's Name

_____ _____

Signature of Patient/Guardian or Personal Representative Date

_____

Personal Representative's Title (e.g., guardian, executor of estate, health care power of attorney)

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____