Drs. Onstott, Farris & Fisher Family Dentistry

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**Patient Information Form**

Name Date

First Middle Last

Address City State Zip

Cell # Home phone Soc. Security # Birthdate

Email

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If college student, F.T/P.T., name of school City State

Patient or parent’s employer Work phone

Business address City State Zip

Spouse or parent’s name Employer Work phone

Whom may we thank for referring you

Person to contact in case of an emergency Phone

**Responsible Party**

Name of person responsible for this account Relationship to patient

Address Home phone

Driver’s license # Birth Date Soc. Security #

Employer Work phone

Is this person currently a patient in our office Yes No

**Insurance Information**

Name of insured Relationship to patient

Birthdate Soc. Security # Date employed

Name of employer Union or local # Work phone

Employer address City State Zip

Insurance Co. Tel. # Grp. # Policy/I.D.#

How much is your deductible How much have you used Max annual benefit

Do you have any additional insurance Yes No If yes, complete the following:

Name of insured Soc. Security # Date employed

Name of employer Union or local # Work phone

Employer address City State Zip

Insurance Co. Tel. # Grp. # Policy/I.D. #

Ins. Co. address City State. Zip

How much is your deductible How much have you used Max annual benefit

**X**

**Signature of patient (or parent, if minor) Patient number**

MEDICAL HISTORY

Physician Date of Last Visit

Address Phone

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?

Yes No Are you allergic to any medication?

Yes No Do you have a history of a major illness?

Yes No Have you had any operations?

Yes No Have you ever been involved in a serious accident?

Yes No Have you ever smoked or chewed tobacco?

Yes No Have seen a physician in the last 12 months? Why?

Female Patients only:

Yes No Are you pregnant?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia

Anemia Dizziness Herpes Prolonged Bleeding

Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy

Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever

Bone Disorders Heart Problems Kidney problems Tuberculosis

Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

**Please list all medications that you are currently taking**:

# DENTAL HISTORY

Reason for your visit Date of last visit

What concerns you most about your teeth?

Yes No Are you presently in any dental pain?

Yes No Have you ever experienced any unfavorable reaction to dentistry?

Yes No Have your wisdom teeth been removed?

Yes No Have you ever lost or chipped any teeth?

Yes No Have there been any injuries to face, mouth, or teeth?

Yes No Is any part of your mouth sensitive to temperature? Where?

Yes No Is any part of your mouth sensitive to pressure? Where?

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Are you a mouth breather?

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

# Yes No Do you like the appearance of your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE POLICIES**

# FEES - The fee for your treatment is based on the complexity of your case. You will be informed of the fee after your examination.

**PAYMENT** – It is our policy that payment for all services rendered be made in full AT or BEFORE the completion of treatment. We realize that some dental treatment may be of an emergency nature, and that patients may not always be prepared for unexpected dental expenses. To assist you in this regard, we gladly accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

**DENTAL INSURANCE** – If you believe that your treatment is covered by a dental insurance policy, we will be happy to assist you in completing the necessary forms. Please understand that while this is done for your convenience, **we consider each patient to be** **responsible for their entire balance regardless of their insurance coverage.**

If your insurance carrier will reimburse you directly, we ask that your account with our office be paid in full when treatment is rendered.

If you request the insurance carrier to reimburse our dental office, we ask that 50% of the fee be paid when the insurance is submitted. Your account will be adjusted immediately if a credit balance is created after an insurance payment.

**MISSED APPOINTMENTS –** Confirmed appointments require 24 hour notice if you are unable to be present. You can be assessed a MISSED APPOINTMENT FEE ($50 for HYGIENE VISIT and/or $75 for DOCTOR VISIT.)

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient/ Guardian Date**

**I have read and reviewed the information given above, previously provided to the office, and have no changes to make to it.**

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient/ Guardian Date**

**I have read and reviewed the information given above, previously provided to the office, and have no changes to make to it.**

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature of Patient/ Guardian Date**