Welcome to Bunn Family Dentistry !

Thank you for choosing our office for your dental care!

We look forward to serving you as our patient. The following information is being provided to help familiarize you with our office guidelines.

Appointments • Your appointment is a time especially reserved for you. Our appointment system is designed so that we may give the most efficient care in a pleasant and relaxed environment. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We make every effort to call or email our patients as a reminder for an appointment.

Cancellations • We require twenty-four(24) hours advance notice of cancellation.

Missed Appointments •Patients are kindly asked to confirm at least 24 hours prior to the scheduled appointment. Appointments can be confirmed by responding within the electronic notification or calling the office. 1st broken appointment patient will be reminded of the office policy.
2nd broken appointment within a 12 month time frame will be dismissed. _____ (Initial)

Children & Adolescents • We provide children with the same care that our adult patients receive and prefer to care for them as individuals. Parents may accompany children in the operatories by invitation only. We require that parents remain in the building with minor children (under 18 years of age) for the entire appointment.

Technology • Digital radiography, intra-oral photography and Patient Education software are examples of the state of the art technology used in our office for diagnosis and treatment planning.

Sterilization • We follow all recommended sterilization procedures and are compliant with all OSHA regulations.

Investing in • New studies have shown that investing in your oral health, in terms of both prevention and **Your Dental Health** treatment, is not only good for function and aesthetics, but for overall health as well. More recently, the bacteria that causes periodontitis has been linked to an increase in cardiovascular disease. We endeavor to provide our patients with the highest standard of care at an affordable price.

Payments & Insurance • Fees for services are due at the time treatment is rendered. Payment may be made in cash, check, or by Visa, Mastercard, and Discover. We also offer third party financing. As a courtesy to our patients with dental insurance, we will make a good faith estimate of your benefits and file the
appropriate claim forms. **Please ask questions if you do not understand any of these guidelines.** _____ (Initial)

Parents With Young Children •Adult patients scheduled for treatment should not bring their young children to their appointment. When you bring your child with you to your appointment we are unable to do our jobs properly. It is our priority to provide you with the best quality of care.

PATIENT'S NAME:_____
(First) (MI) (Last)
Nickname/Preferred Name:_____

Address_____
City_____State_____Zip _____
Home#_____Cell#_____Work#_____

Email Address_____ ***required***

How would you like our office to notify you of your appointment: Text Email Voice Mail
Circle One

Social Security #_____
Drivers License#_____ ***required***

Occupation_____Employer_____

Date of Birth_____/_____/_____ Age_____ (Month/Day/Year)

Gender Male / Female ***Please circle***

In case of emergency
contact:_____*Phone:_____

How did you hear about us? (please check all that apply)
___Flier ___Franklin Times ___Friend
___Drive by/Location ___Insurance ___Online ___ Nashville Graphic ___
___Referred by_____Other_____(Please specify name) (Please specify)

*** RESPONSIBLE PARTY (if other than the patient)**
Name_____Relationship_____
(First) (MI) (Last)
Street
Address_____
___City_____State_____Zip_____
Telephone:
Home_____Cell_____Work_____

***INSURANCE POLICY**

Name of
Insured_____Relationship_____
(First) (MI) (Last)
Date of Birth_____/_____/_____
(Month/Day/Year)
Social Security#_____
Employer_____
Insurance Company_____
Policy#_____Group#_____
ID#_____

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract.

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.
2. Our office policy states that you are responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.
3. We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.
4. Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.
5. **If your coverage changes for any reason, please notify the office immediately.**

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

X

_____

(Signature) (Date)

Time 9:06 AM

Bunn Family Dentistry

Eaglesoft Medical History

Date 9/18/2015

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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:

X Date:_____

Acknowledgment of Receipt

I acknowledge that I have read a copy of Bunn Family Dentistry's Notice of Privacy of Practices.

Patients Name (**Print**) _____

Signature _____

Date _____