Magnolia Dental Group

4005 Cedar Glades Dr., Unit C, Murfreesboro, TN 37128
New patient Demographic Form

First Name: ______________________ Middle Initial: ______ Last Name: ______________________________

What name does the patient prefer to go by?: ________________________________

Gender: Male / Female / Undecided (circle one)

Birth Date:________________________________

SSN: ________________________________

Email Address: ____

Phone Number: ________________________________

Type: ________________________________

Address Line 1: ____

Address Line 2: _______________________________ ________________________________

City: ________________________________

State/Province/Region: ________________________________

Postal Code: ________________________________

Who is filling out the form today?: ________________________________ **(If yourself, write same as above)**

Please provide your first and last name

First Name: ________________________________ Last Name: ________________________________

Phone Number: ________________________________

Who has legal custody of the patient?: ________________________________

Primary Contact Details - who should we contact for scheduling? **(If yourself, write same as above)**

Primary Contact Name: ________________________________

Relationship to Patient: ________________________________

Phone Number: ________________________________

Address Line 1: ____

Address Line 2: ____

City: ________________________________

State/Province/Region: ________________________________

Postal Code: ________________________________

How did you hear about us?: ________________________________

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Is the patient also the guarantor? ________________________________

Guarantor First Name: ________________________________

Guarantor Last Name: ________________________________

Relationship to Patient: ________________________________

Phone Number: ________________________________

Address Line 1: ____

Address Line 2: ____

City: ________________________________

State/Province/Region: ________________________________

Postal Code: ________________________________

EMPLOYMENT DETAILS

Occupation: ________________________________

How long?: ________________________________

Employer Name: ________________________________

Please list 2 contact names to whom practice can release PHI information (HIPAA) [you do not have to put anyone if you do not want too]:

First Name: ________________________________

Last Name: ________________________________

Phone Number: ________________________________

First Name: ________________________________

Last Name: ________________________________

Phone Number: ________________________________

EMERGENCY CONTACT

First Name: ________________________________

Last Name: ________________________________

Phone Number: ________________________________

By signing below you confirm that I, the patient or patient guardian, attest that all of the information provided above is correct and accurate.

Signature: ____

Dental Insurance

Do you have dental insurance? Yes or No (circle one)

Name of Insured: ____

Insured's Birth Date: ____

Insured's Address Line 1: ____

Insured's Address Line 2: ____

Insured's City: ____

Insured's State: ____

Insured's Postal Code: ____

Patient's Relationship to Insured: ____ (self, spouse, guardian)

Insured's Employer Name: ____

Employer's Address Line 1: ____

Employer's Address Line 2: ____

Employer's City: ____

Employer's State: ____

Employer's Postal Code: ____

Carrier Name: ____

Plan Name: ____

ID #: ____

Group #: ____

Insurance Company Phone Number: ____

Insurance's Address Line 1: ____

Insurance's Address Line 2: ____

Insurance's City: ____

Insurance's State: ____

Insurance's Postal Code: ____

Do you have Secondary Insurance? Yes or No (circle one). If yes, fill out the information below.

Name of Insured: ____

Insured's Birth Date: ____

Insured's Address Line 1: ____

Insured's Address Line 2: ____

Insured's City: ____

Insured's State: ____

Insured's Postal Code: ____

Patient's Relationship to Insured: ____ (self, spouse, guardian)

Insured's Employer Name: ____

Employer's Address Line 1: ____

Employer's Address Line 2: ____

Employer's City: ____

Employer's State: ____

Employer's Postal Code: ____

Carrier Name: ____

Plan Name: ____

ID #: ____

Group #: ____

Insurance Company Phone Number: ____

Insurance's Address Line 1: ____

Insurance's Address Line 2: ____

Insurance's City: ____

Insurance's State: ____

Insurance's Postal Code: ____

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Signature: ____

Dental History

Is the patient a minor?Yes or No (circle one)   Is this your child's first dentist visit? Yes or No (circle one)

Please provide the following previous provider details:

Provider Name: ____

Provider Phone Number: ____

Why did you leave your previous dentist? ____

What did you like most about your previous dentist?
____

What did you like least about your previous dentist?
____

Does your child have any of the following?

Cavities/Decay? _____ Lip sucking/biting? _____ Speech problems_____ Nail biting _____
Pacifier/Thumb/Finger sucking _____ Mouth breathing _____ Tongue thrust _____ Nursing/bottle habits _____
Jaw problems _____ Grinding teeth _____ Has the patient ever had orthodontic treatment (braces)? _____
Has the patient ever had any pain/tenderness in their jaw joint (TMJ/TMD)? _____

Reason for visit? ____

Date of last dental visit? _______________   Date of last dental x-rays? _______________
How often do you floss? _______________   How often do you brush? _______________

Do you have bad breath? _____ Bleeding, red, swollen gums? _____ Broken/loose teeth or fillings? _____
Clicking or popping jaws? _____ Pain around ear/side of face? _____ Sores/Blisters in mouth? _____
List any other dental concerns/pain: ____________________________________

Are you interested in whitening your smile? _________
Are you happy with your smile? If not, what would you change?
____
____
____

Signature: ____

Medical History

Do you have allergies to any of the following?

Aspirin? ____ Codeine? ____ Latex? ____ Local anesthetic? ____ Penicillin? ____ Clindamycin? ____

Sulfa drugs? ____ List any other allergies: ____

Do you have any of the following?	Yes	No
Abnormal (high/low) blood pressure	____	____
AIDS/HIV	____	____
Anemia/Bleeding problems	____	____
Arthritis/Rheumatism/Gout	____	____
Artificial heart valve	____	____
Artificial Joints	____	____
Asthma	____	____
Blood disease	____	____
Cancer/Chemotherapy	____	____
Congenital heart lesions	____	____
Diabetes	____	____
Emphysema	____	____
Epilepsy	____	____
Fainting/Dizziness	____	____
Glaucoma	____	____
Headaches (frequent)	____	____
Heart problems	____	____
Heart murmur	____	____
Hepatitis (A/B/C)	____	____
Herpes	____	____
Kidney disease	____	____
Liver disease	____	____
Nervous problems	____	____
Psychiatric care	____	____
Pacemaker	____	____
Radiation treatment	____	____
Shortness of breath (breathing problems)	____	____
Sinus trouble	____	____
Stroke	____	____
Thyroid problems	____	____
Tuberculosis	____	____
Tumor/Growth on head/neck	____	____
Ulcers	____	____

Please list any other medical issues you have:

____

____

List any serious illnesses/surgeries/hospitalizations:

____

____

Are you taking any medications? Yes or No (circle one)

List medications you are taking:

____

Do you smoke? Yes or No | Do you drink alcohol? Yes or No | High sugar intake? Yes or No

Are you pregnant? Yes or No | Are you nursing? Yes or No

Are you under care of a physician? Yes or No

Physician Name:

Physician phone number: ____

Is the patient physically, mentally or emotionally impaired?

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Signature: ____

Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care.

Financial responsibility on the part of each patient must be determined before treatment.

As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

- All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.
- All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account. We will accept assignment of benefits for primary and secondary insurance.
- Fee estimates for dental care can only be extended for a period of ninety (90) days from the date of consultation.
- Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.
- Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.
- If you wish to receive a copy of the full financial disclosure, please ask and we will provide it for you.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

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Signature: ____

Radiographs and Insurance

We will recommend that certain radiographs (x-rays) be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us and we will discuss the situation further.

Cancellation Policy

If you find that you must change your appointment, we require 24 hours advance notice so that we may make every effort to accommodate other patients. If proper notice is not received, you may be charged a fee of $25 for every canceled appointment.

Late Arrival Policy

Your appointment was scheduled to allow enough time to provide the best service to you. Patients who arrive for their appointments more than 15 minutes late may have to be rescheduled. If you need to be rescheduled, you may be charged a $25 fee.

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Signature: ______________________________________