Welcome to Our Practice

Christopher S. Mathews, D.M.D.
P.O. Box 819
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Family Dentistry
www.mathewsdental.com
931-598-0088

Today's Date _____

Name of Patient _____ Birthdate _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ School Phone _____ Work Phone _____

Cell Phone _____ E-mail _____ SSN _____ Gender _____

Patient Employed by _____ Position held _____

Name of Spouse(If patient is under 21, name of parent) _____

In case of emergency, who should be notified (not your spouse): _____ phone _____

Purpose of today's appointment _____

• • • • • • • • • • Insurance Information • • • • • • • • • •

Do you have dental insurance? Yes___ No___ If yes, name of company _____

Name of policy holder _____ Policy Holder's SSN _____ birthdate _____

Do you have secondary dental insurance? Yes___ No___ If yes, name of company _____

Name of policy holder _____ Policy Holder's SSN _____ birthdate _____

Policy holder's employer _____ Phone _____

Please hand your card to our front desk manager to copy and return to you.

• • • • • • • • • • • Medical History • • • • • • • • • • •

Have you ever had any of the following? Please circle yes or no. The "yes" is to the left of the condition; "no" is to the right.

Yes	**Heart Disease** No	Yes	**Epilepsy** No	Yes	**Hemophilia** No
Yes	**Heart Murmur** No	Yes	**Blood Disease** No	Yes	**STD** No
Yes	**Heart Surgery** No	Yes	**Eye Surgery** No	Yes	**Herpes** No
Yes	**Heart Valve Replacement** No	Yes	**Glaucoma** No	Yes	**AIDS/HIV Positive** No
Yes	**Endocarditis** No	Yes	**Radiation Treatment** No	Yes	**Tuberculosis** No
Yes	**Pacemaker** No	Yes	**IV Chemotherapy** No	Yes	**High Blood Pressure** No
Yes	**Joint Replacement** No	Yes	**Blood Transfusion** No	Yes	**Asthma** No
Yes	**Hepatitis** No	Yes	**Arthritis** No	Yes	**Cancer** No
Yes	**Stroke** No	Yes	**Kidney Disease** No	Yes	**Liver Disease** No
Yes	**Diabetes** No	Yes	**Osteoporosis** No	Yes	**Gastric Ulcers** No

Physician's Name _____ City _____

Medications you are currently taking: _____

_____

_____

List all drugs or medications to which you have a reaction or allergy:

_____

Major Surgeries and approximate date of surgery _____

Other Conditions: _____

Please note: the taking of antibiotics can reduce the effectiveness of birth control pills.

Do you wear contact lens? Yes____ No____ Are you allergic to Latex? Yes_____No_____

Do you use tobacco products? Yes ____No___ If yes, what type? _____

Are you pregnant? Yes____ No____ Is your blood pressure normal? Yes_____ No_____Date last checked _____

Are you currently taking any blood thinning medications? Yes_____ No_____

Are you currently taking any medication for osteoporosis? Yes_____ No_____ How long have you taken it? _____

Do you object to the use of Nitrous Oxide (laughing gas)? _____

Have you ever been required to take antibiotics before having your teeth cleaned? Yes___ No___If yes, explain _____

If you have had heart or joint surgery, please list your specialist's name, address and phone number:

_____

Have you ever had problems with local anesthesia (numbing your teeth)? Yes_____ No_____ Explain _____

Have you had serious problems associated with dental treatment? Yes_____ No_____ Explain_____

Please share with us who or what referred you to our practice? _____

I, the undersigned, certify and acknowledge the following:

I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other healthcare providers and institutions.

I am 18 years or older. If you are under 18, your parent or guardian must sign this form.

I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.

I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage.

I assume responsibility for all the costs of collections, including financial charges, attorney fees and court costs.

I understand that dental insurance companies rarely cover 100% of all dental expenses.

I have checked and know that my insurance company accepts Dr. Mathews as a covered provider.

I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.

I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized two working days prior to the original appointment or a late cancellation fee may be charged.

I have accurately answered all the questions and have read all the above information.

Signature_____ Relationship to Patient_____

Print name_____

Initials	Date	DR	Initials	Date	DR	Initials	Date	DR	Initials	Date	DR	Initials	Date	DR