THE DENTAL COTTAGE
DR. KRISTY STANISLAV, DDS
DR. DAWSON NICHOLSON, DDS

P 931-648-0232 • F 931-905-1406
1827 Memorial Drive, Clarksville, TN 37043
info@thedentalcottage.com

PATIENT INFORMATION

Thank you for trusting us with your health care. We promise to do out best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____ Phone _____

When is the best time to reach you? _____

Sex: ☐ M ☐ F Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age _____ Birthdate _____ SS# _____

Occupation _____ Employer _____

Employer Address _____ Phone _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Phone _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT *(Please specify someone who does not live in your household.)*

Name _____ Relationship _____

Home Phone _____ Work Phone _____

DENTAL INSURANCE

Who is responsible for this account? _____

What is their relationship to the patient? _____

Insurance Company _____ Group # _____

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DENTAL INSURANCE CONTINUED

Is the patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Birthdate _____

SS# _____ Relationship to Patient? _____

Insurance Company _____ Group # _____

DENTAL INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist _____ City/State _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Do you have, or have you had, any of the following? (circle below)

Bad Breath	Yes	No	Food collection between teeth	Yes	No	Pain around ear	Yes	No
Bleeding Gums	Yes	No	Foreign objects	Yes	No	Periodontal treatment	Yes	No
Blisters on lips or mouth	Yes	No	Grinding teeth	Yes	No	Sensitivity to cold	Yes	No
Burning sensation on tongue	Yes	No	Gums swollen or tender	Yes	No	Sensitivity to heat	Yes	No
Chew on one side of mouth	Yes	No	Jaw pain or tiredness	Yes	No	Sensitivity to sweets	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No	Loose teeth or broken fillings	Yes	No	Sensitivity when biting	Yes	No
Clicking or popping jaw	Yes	No	Mouth breathing	Yes	No	Sores or growths in your mouth	Yes	No
Dry mouth	Yes	No	Mouth pain, brushing	Yes	No			
Fingernail biting	Yes	No	Orthodontic treatment	Yes	No			

How often do you brush? _____

How often do you floss? _____

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EAGLESOFT MEDICAL HISTORY

Patient Name _____ Date of Birth _____ 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? ☐ No ☐ Yes: _____

Have you ever been hospitalized or had a major operation? ☐ No ☐ Yes: _____

Have you ever had a serious head or neck injury? ☐ No ☐ Yes: _____

Are you taking any medications, pills, or drugs? ☐ No ☐ Yes: _____

Do you take , or have you taken, Phen-Fen or Redux? ☐ No ☐ Yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ No ☐ Yes: _____

Are you on a special diet? ☐ No ☐ Yes: _____

Do you use tobacco you use tobacco? ☐ No ☐ Yes: _____

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? ☐ No ☐ Yes: _____

Do you use controlled substances? ☐ No ☐ Yes: _____

Do you have, or have you had, any of the following? *(circle below)*

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

Have you ever had any serious illness not listed? ☐ No ☐ 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 _____ Date _____

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PATIENT CONSENT

Clinical

1. I authorize The Dental Cottage to perform all recommended treatment.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize such Diagnostic Material may be released to third-party payors and/or other health professionals.
3. I authorize the use of anesthesia, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risk, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received a copy of the Notice of Privacy Practices of The Dental Cottage. I hereby authorize, as indicated by my signature below, The Dental Cottage to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name _____ Address _____

Signature _____ Date _____

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me at my mobile telephone number _____

☐ You may contact me at my work telephone number _____

☐ You may send me an e-mail at _____

☐ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed _____
2. _____ Date Added/Removed _____
3. _____ Date Added/Removed _____
4. _____ Date Added/Removed _____
5. _____ Date Added/Removed _____

*** * * 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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify): _____

Staff Person Initials: _____