RUSSELL BOYTER DDS
STONES RIVER DENTAL

Medical History

1630 NW Broad St. Ste. 101, Murfreesboro, TN 37129 • 615.896.0608 • stonesriverdental.com

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?	☐ Yes	☐ No	If yes _____
Do you use any controlled substances?	☐ Yes	☐ No	If yes _____

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

☐ AIDS/HIV Positive	☐ Diabetes	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Drug Addiction	☐ Herpes	☐ Rheumatism
☐ Anaphylaxis	☐ Easily Winded	☐ High Blood Pressure	☐ Scarlet Fever
☐ Anemia	☐ Emphysema	☐ High Cholesterol	☐ Shingles
☐ Angina	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Artificial Joint	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Disease	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Breathing Problems	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Bruise Easily	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Hay Fever	☐ Osteoporosis	☐ Tumors or Growths
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Ulcers
☐ Chest Pains	☐ Heart Murmur	☐ Parathyroid Disease	☐ Venereal Disease
☐ Cold Sores/Fever Blisters	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Congenital Heart Disorder	☐ Heart Trouble/Disease	☐ Radiation Treatments	☐ Other:
☐ Convulsions	☐ Hemophilia	☐ Recent Weigh Loss	
☐ Cortisone Medicine	☐ Hepatitis A	☐ Renal Dialysis	_____

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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Acknowledgement of Receipt of Notice of Privacy Policies

Minor

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I have received a copy of the Notice of Privacy Practices of Stones River Dental.
I hereby authorize, as indicated by my signature below, 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 _____

You may contact me at the following:

- ☐ Home phone number
- ☐ Cellphone number
- ☐ Work phone number
- ☐ E-Mail _____
- ☐ 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: _____

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
- ☐ An emergency situation prevent us from obtaining the acknoledgement
- ☐ Other (please specify) _____

Staff Person's Initials _____

RUSSELL BOYTER DDS
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Acknowledgement of Receipt of Notice of Privacy Policies

Adult

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I have received a copy of the Notice of Privacy Practices of Stones River Dental.
I hereby authorize, as indicated by my signature below, 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 _____

You may contact me at the following:

- ☐ Home phone number
- ☐ Cellphone number
- ☐ Work phone number
- ☐ E-Mail _____
- ☐ 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: _____

OFFICE USE ONLY

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- ☐ Individual refused to sign
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- ☐ Other (please specify) _____

Staff Person's Initials _____

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Office Policies

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I understand and give my permission to **Stones River Dental** to perform diagnostic services to better determine the appropriate treatment needed for my proper dental care. These diagnostic services may include any or all of the following: x-rays, oral examination, biopsy, periodontal evaluation, probing or any other necessary service to help **Stones River Dental** make an adequate diagnosis.

Once a diagnosis is made, I will be given a treatment plan. This plan is an **estimated** cost of the recommended treatment and the anticipated financial responsibility on my behalf. I understand that once the treatment is performed, if my insurance company denies the treatment, or if they pay less than expected, then I am responsible for any remaining balances. Furthermore, I understand and agree that my estimated portion of any and all treatment will be paid upon the day of services. Forms of payment include Cash, Visa, MasterCard, American Express, Discover, Personal Check and Care Credit.

As a courtesy, **Stones River Dental**, will file a Pre-Estimate, at my request, for any recommended treatment to help better determine what I can expect my portion to be. Additionally, as a courtesy, when the treatment is performed, **Stones River Dental** will file my insurance for payment. However, I understand and agree that if my insurance company fails to pay within 30 days, or if they pay less than expected, I become immediately responsible for the balance remaining and will pay such balance upon receipt of statement.

If my delinquent account results in collection proceedings, then all additional collection costs, court cost and legal fees will be paid by me.

Stones River Dental does not charge a cancellation fee for missed or canceled appointments. However, we do ask as a courtesy that you provide a **48-hour notice** if you need to reschedule or cancel an appointment. Failure to do so will result in the inability to assign future appointment time.

I grant my permission to **Stones River Dental** to call me at home, work, or cellphone to discuss matters related to my treatment, financial obligations, or appointments.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent (If Patient is a Minor) Date

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Dental History

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Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, chipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ____/____

Your last oral cancer screening ____/____

Your last complete X-Rays ____/____

Name of Previous Dentist

_____

City _____

State _____

Phone Number _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

Do you smoke or use chewing tobacco? How much? For how long?

_____

If you could change your smile, you would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1–10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your future smile and dental health?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____