Fesmire Dental Group
6200 Highway 100, Suite #200
Nashville, TN 37205

NEW PATIENT REGISTRATION AND HEALTH HISTORY

Patients Name________________________________How do you prefer to be addressed?_____________________
Mailing Address____________________________________City__________________State_______Zip_____ _____
Sex: M F Age:_______ Birth Date:___________ Single Married Widow Separated Divorced SS#:________________
Home Phone:______________________ Cell Phone:______________________ Work Phone:_____________________
Occupation:_____________________________________ Employer:____
Employer's Address:_________________________________City____________________State ______Zip_______
If Student, Name of School/College:______________________City____________________State_______Zip_______
Emergency Contact Person/Relationship/Phone #:____
Whom may we thank for referring you to our office?____
How would you prefer to be contacted? Email:___________________________Home/Work/Cell (please circle one)

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, skip to the section titled "Insurance Information".

Name of responsible party____Relationship to patient________________
Mailing Address____________________________________City__________________State_______Zip___________
Sex: M F Age:_______ Birth Date___________ Single Married Widow Separated Divorced SS#:________________
Home Phone:______________________ Cell Phone:______________________ Work Phone:_____________________

Insurance Information

Policy Holders Name_______________________Relationship to Patient___________SS#___________DOB_______
Name of Employer_______________________________Employer Address_________________________State_____
Insurance Company_________________Group #__________Address_______________________________________

Secondary Insurance Information

Policy Holders Name_______________________Relationship to Patient___________SS#___________DOB_______
Name of Employer_______________________________Employer Address_________________________State_____
Insurance Company_________________Group #__________Address_______________________________________

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any of your family been seen by us before? Yes No
   If yes, which family member?___________________________
2. Date of last physical examination_________________________Physician's name_________________
3. Date of last dental examination__________________________Date of last dental xrays___________
4. Previous Dentist name_________________________________City/State________________________
5. Are you having pain or discomfort at this time? Yes No
6. Do you feel nervous about having dental treatment? Yes No
7. Have you ever had a bad experience in a dental office? Yes No
8. Is there anything you would like to speak to the doctor about in private? Yes No
9. Is there anything you dislike about your smile? Yes No
10. Have you been a patient in the hospital in the past two years? Yes No
11. Have you been under the care of a medical doctor in the past two years? Yes No
12. Have you taken any medications or drugs in the past two years? Yes No
13. Are you taking any vitamins, herbal supplements? Yes No
14. Have you ever had any extensive bleeding requiring special treatment? Yes No

Time 4:07 PM Robert C. Fesmire, DDS Date 5/6/2020

Eaglesoft Medical History

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, c

Question	Answer	
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	
Do you use controlled substances?	◯ Yes ◯ No	If 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? ☐ If yes

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

Condition		Condition		Condition		Condition	
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 above? ◯ 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:__________

FINANCIAL/OFFICE POLICIES

Fesmire Dental Group
6200 Highway 100, Suite #200
Nashville, TN 37205
Office: 615-352-1332
Fax: 615-352-1303

Please initial by each one:

_______* We will be glad to file your insurance claim for you. However, you will be held responsible for copays, previous balances, deductibles, and treatments not covered by your insurance carrier. **Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

_______* Broken appointments without prior notification are a burden to all. We do our best to run on time, and we ask that you do the same. We respectfully ask you to give us a 24-hour cancellation notice so that we can schedule other patients. **Missed appointments without 24-hour notification are subject to $40.00 disappointment fee.**

_______* When we verify your benefits, your carrier will give us the general provisions of your coverage plan along with **estimated** benefit amounts. Actual claims may vary, so we will not know the exact dollar amount until the claim is actually paid.

_______* As a courtesy, we will be happy to assist you in interpreting and understanding the terms of your dental insurance to the best of our ability. However, these kinds of questions are often better answered by your insurance carrier.

_______* **Fesmire Dental Group** does require payment in full for your portion **at the time of service.** We accept Visa, MasterCard, Discover, American Express, Care Credit, cash, and checks.

_______* If your insurance company does not pay within 45 days, **Fesmire Dental Group** reserves the right to request in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal cantract between **YOU** and your insurance company.

***I agree with the above conditions.**

Print name:____Date:_________________________

Patient/Parent Signature:____

<u>Oral Cancer Screening Consent Form</u>

We are concerned about oral cancer, and conduct a screening examination on every patient.

The incidence of oral cancer continues to rise in the USA. The American Cancer Society estimates there will be roughly 53,000 new cases of oral and pharyngeal cancer this year. **Alarmingly, 25% of the new oral cancer cases are people that do not have any traditional lifestyle risk factors such as age and tobacco and alcohol use.**

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The VELscope (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to the other early detection procedures (like colonoscopy, mammography, etc.) is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope hand piece and the hygienist or dentist may find tissue abnormalities at an earlier stage. These abnormalities can range from something minor to something of greater concern that may require further examination and follow-up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurances. **The fee for this enhanced examination is <u>$20</u>.** As part of our standard of care and because we care about you, we strongly recommend that you choose for this additional screening procedure.

Please sign the area below to accept the financial responsibility for this procedure.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients. Thank you for your kind consideration.

YES

I authorize the office to perform the VELscope examination

NO, not today

You may request the screening at any future appointment

Print Name____

Signature____ Date_____________________

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have to right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signed this ________ day of____________20_________

Print Patient Name______________________________

Signature______________________________________

Relationship to Patient____________________________