ROBERT R. SULLIVAN, D.D.S.
General and Cosmetic Dentistry
131 Maple Row Blvd, Suite D402 • Hendersonville, TN 37075
Phone: (615) 824-2181

PATIENT INFORMATION

Date: _____

Name: _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
LAST FIRST M

Address: _____
STREET APT. # CITY STATE ZIP

Birthdate: _____ Age _____ Telephone: _____ _____ _____
MO. DAY YR. HOME OFFICE CELL

Employer (or School): _____ Grade _____ S.S. # _____

Address: _____ Position: _____ Supervisor: _____

Dental Insurance Co.: _____ Group No. _____

Has any member of your family ever been treated in our office: ☐ Yes ☐ No _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

	FATHER (OR HUSBAND OR GUARDIAN)	MOTHER (OR WIFE)
Name:	_____ LAST FIRST M	_____ LAST FIRST M
Address:	_____ STREET CITY STATE ZIP	_____ STREET CITY STATE ZIP
Telephone #:	_____ HOME _____ OFFICE _____ CELL	_____ HOME _____ OFFICE _____ CELL
Birthdate/SS #:	_____ MO DAY YR SS #	_____ MO DAY YR SS #
Employer: Dental Insurance Co:	_____ EMPLOYER	_____ EMPLOYER
Group #:	_____ DENTAL INSURANCE GROUP #	_____ DENTAL INSURANCE GROUP #

Name and age of other family members: _____

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
☐ Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name _____ Tel. # _____
LAST FIRST M

Address _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

☐ Credit Card ☐ Cash ☐ Check ☐ Insurance (your portion due today)
☐ MedicCount # _____ Name of Bank and Account Number _____

AGREEMENT

Insurance — I understand that the portion of my treatment not covered by insurance is due and payable at each visit. I also understand that my dental insurance is a contract between me and the insurance carrier, not between the insurance carrier and the dentist, and that I am still responsible for all dental fees. If my insurance company has not paid their portion within 60 days of being properly billed, I understand that the balance will become due and payable from me.

Missed Appointments — A missed appointment is a loss to everyone. I understand that I may be charged a fee for broken appointments with less than 24 hrs. notice.

Late Charge — If I do not pay the entire New Balance (the "Amount Due Now" on your statement) within 30 days of the date of service, a LATE CHARGE will be added to my account for the current monthly billing period. The LATE CHARGE will be a periodic rate of 1.50% per month (or a minimum charge of $1.00 for a balance under $57.00) which is an ANNUAL PERCENTAGE RATE of 18%. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection, court, and reasonable attorney fees incurred to effect collection on this account.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment (including cosmetic), medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

_____ _____
(Signature of responsible party) (Relationship to other(s) named)

Please complete information on other side

MEDICAL HISTORY

Physician_____ Address_____

Date of last medical exam_____ Are you under the care of a physician now? ❑ YES ❑ NO

Comments_____

_____

Are you taking any medications or drugs? ❑ YES ❑ NO (including aspirin)

If yes, please list drug(s)_____

Have you ever had an unfavorable reaction to any medicine (such as Penicillin, aspirin or novocaine)? ❑ YES ❑ NO

If yes, please explain_____

Have you had any problems with any of the following?

❑ YES ❑ NO heart disease	❑ YES ❑ NO lung disease	❑ YES ❑ NO swelling	❑ YES ❑ NO drug reaction
❑ YES ❑ NO heart murmur	❑ YES ❑ NO diabetes	❑ YES ❑ NO liver	❑ YES ❑ NO hearing
❑ YES ❑ NO rheumatic fever	❑ YES ❑ NO asthma	❑ YES ❑ NO kidney	❑ YES ❑ NO epilepsy
❑ YES ❑ NO bleeding	❑ YES ❑ NO allergies	❑ YES ❑ NO cleft lip / palate	❑ YES ❑ NO convulsions
❑ YES ❑ NO hepatitis	❑ YES ❑ NO anemia	❑ YES ❑ NO speech problems	❑ YES ❑ NO eye problems
❑ YES ❑ NO high/low blood press.	❑ YES ❑ NO osteoporoses	❑ YES ❑ NO hayfever	❑ YES ❑ NO tumor/cancer
❑ YES ❑ NO weight loss	❑ YES ❑ NO phen-phen/redux	❑ YES ❑ NO difficulty opening	❑ YES ❑ NO HIV/Aids
❑ YES ❑ NO Latex Allergy	❑ YES ❑ NO emotional, mental or	or closing jaw	❑ YES ❑ NO injury to face
❑ YES ❑ NO biophosphonates (Fosomax, Actonel, etc.)	nervous disorder		or jaw

Do you wish to speak to the doctor privately about anything? ❑ YES ❑ NO

Please describe any other medical information we should be aware of that we have not discussed_____

_____

Has any member of your immediate family had problems with any of the above?_____

_____

May we request release of your medical records for our reference?_____

Have you ever been hospitalized?_____ if yes, give date(s), hospital and reason_____

_____

FOR WOMEN ONLY Are you pregnant? ❑ YES ❑ NO If so, due date_____ Are you nursing? ❑ YES ❑ NO

Are you on birth control pills, patch or implant? ❑ YES ❑ NO

DENTAL HISTORY

Briefly explain why you are seeking dental care_____

Your last dental visit_____ Name of previous dentist_____

Please state any goals you may have to improve your teeth_____

Have you had any problems with the following:

❑ YES ❑ NO cavities	❑ YES ❑ NO teeth sensitive to hot/cold	❑ YES ❑ NO teeth sensitive to sweets
❑ YES ❑ NO crooked teeth	❑ YES ❑ NO toothache/hurts to bite date_____	❑ YES ❑ NO color of teeth
❑ YES ❑ NO red, bleeding or swollen gums	❑ YES ❑ NO teeth bumped or broken date_____	❑ YES ❑ NO grinding or clenching

Other dental problems_____

MEDICAL UPDATE HISTORY

1. Date:_____ Changes:_____ Reviewer's initials: _____
2. Date:_____ Changes:_____ Reviewer's initials: _____
3. Date:_____ Changes:_____ Reviewer's initials: _____
4. Date:_____ Changes:_____ Reviewer's initials: _____