CHESEMORE DENTAL GROUP

DAVID B. TRAVIS, DDS   ROBERT WHITFIELD, DDS   ROBERT M. FIELDS, DDS   DAVID B. TRAVIS JR., DDS   BROOKE OVERBEY, DDS

715 Morton Street, Paris, Tennessee 38242 • 180 Hospital Drive, Camden, Tennessee 38320

PATIENT INFORMATION

Date ______________ Patient Name ________________________ Male _____ Female _____
Date of birth ______________ Age _____ Social Security # ______________________
Address ____ Apt. __________
City_________________________________ State________ Zip__________
Marital Status: Married ____ Divorced ____ Widowed ____ Spouse ______________________
Home Phone __________________ Cell Phone __________________ Email ______________
Drivers License# ___________________________ or Other ID ______________________
Employer ________________________________ Employer phone ______________________
Employer address ________________________________ Occupation, ________________
Emergency contact ___________________________ Phone ______________________
Person Responsible for Payment ______________________ Relationship to Patient __________
Responsible Party's Address ___________________________________ Phone __________
I authorize Chesemore Dental Group to contact Responsible Party prior to treatment __ yes __ no

INSURANCE INFORMATION

Insured's Name ____________________ Date of Birth __________ Social Security # ______________
Insurance Co. ____________________ Policy ______________ ID# ______________________
Insurance is through Employer _____yes _____no _____ Insurance provided by ______________________
Additional Insurance Co. ______________________ Policy#______________ ID# ______________
Insured's Name ______________________ Date of Birth __________ Social Security#______________
Insurance is through an employer ____yes _____no Insurance is provided by : ______________________

AUTHORIZATIONS AND UNDERSTANDING Of PAYMENT POLICIES

I certify that the information that I have given is correct to the best of my knowledge. I understand that it will be held in strict confidence and that it is **MY RESPONSIBILITY** to inform staff members and this office of any change in medical condition at each office visit. I authorize the dental staff of The Chesemore Dental Group to perform the services that I need.
Signed ____

I further affirm that I understand that payment for services rendered are payable by cash, check or approved credit card unless specific arrangements are made with the business office prior to any treatment. I understand that Chesemore Dental Group has sole discretion in the acceptance of individual credit cards. I understand that unpaid account balances are charged a 1.5% monthly finance charge. Signed, ____

I understand that if this account is placed for collection by an attorney or collection agency, by suit or otherwise, I/we agree to pay all collection costs, including any reasonable attorney and court fees. Signed ____________________________ I certify that I am covered by ____________________________ Insurance Company and I assign directly to Drs. Travis Whitfield and Fields all insurance benefits, otherwise payable by me. I understand that I am ultimately responsible for payment of all charges for services rendered, should my insurance company decline any coverage for any reason. I understand that I am responsible for any deductible and/or co-pay that my insurance does not cover and that payment for these deductibles and co-pays are due prior to the start of treatment. I hereby authorize Chesemore Dental Group to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions.

Signed ____________________________________ Date ____________________

MEDICAL HISTORY

Name ______________________________ Address ____

Primary Care Physician : ____

Date of Last Medical Visit:____________

Your current health is ___good ____fair ____poor

Do you use tobacco products? ____yes ____no

Women: Are you currently pregnant? ____yes ____no Nursing? _____yes ____no

Names and telephone of all physicians currently providing care: ______________________________________

____

ALLERGIES

___no allergies ___Aspirin ___Codeine ___Erythromycin ___Sulfa drugs ___latex ___metal ___Ibuprofen ___Penicillin ___Tylenol ___ Clindamycin ___ Lortab/Norco ___local anesthetics

Are you currently or have you been treated:

____ joint replacement
____ heart valve replacement
____ heart attack/disease
____ heart surgery
____ pacemaker
____ cold sores/fever blisters
____ radiation treatment
____ pain in jaw
____ anemia/blood disorder

_____healing complications
_____hemophilia
_____diabetes
_____seizures
_____epilepsy
_____fainting/dizziness
_____asthma
_____emphysema/COPD
_____kidney disease

____ leukemia
____ abnormal bleeding
____ high blood pressure
____ thyroid disease
____ blood transfusion
____ hepatitis
____ tuberculosis
____ cancer
____ bleeding gums

____ liver disease
____ stroke
____ renal dialysis
____ lupus
____ glaucoma
____ venereal disease
____ HIV/AIDS
____ ADD/ADHD

List all other health problems: ____

____

List all major surgeries and/or hospitalizations: ____

____

Medications

Are you currently taking: aspirin or blood thinners? ___yes ___no

Are you currently taking, or have you taken in the past, OSTEOPOROSIS medications such as : Fosamax, Aredia, Zometa, Actonel, Bonita ? ___yes ___no

Please check any of the following medications you are taking:

__ acetaminophen
__ aspirin
__ heart medications
__ nitroglycerin

__ cold remedies
__ antihistamines
__ antibiotics
__ steroids

__ insulin
__ blood pressure medication
__ cholesterol medication
__ recreational drugs

__ thyroid medication
__ behavioral medication

I take no medication ___

List all current medications, vitamins & supplements you are currently taking:

____

____

I CERTIFY THAT I HAVE ANSWERED THE ABOVE ACCURATELY AND TO THE BEST OF MY ABILITY.

SIGNED ____ DATE ____________________________

Chart Information Updated:

date _______________patient/legal guardian signature ______________________________

date _______________patient/legal guardian signature ______________________________

date _______________patient/legal guardian signature ______________________________

FINANCIAL RESPONSIBILITIES and PAYMENT

I UNDERSTAND THAT AS THE RESPONSIBLE PARTY, I AM PERSONALLY RESPONSIBLE FOR ANY FEES FOR SERVICES AND TREATMENTS RECEIVED REGARDLESS OF INSURANCE COVERAGE

We accept cash, checks and most Visa and Master Card, however we reserve the right to deny use of any credit cards charging processing fees above 3%. Payment is due at the time treatment is performed. We do not offer in house charge accounts. Any balances not paid will be charged 1.5% interest rate and may incur late fees. If your insurance denies your claim you will be responsible for any unpaid balances. They must be paid within 30 days of notification or be subject to additional late fees.

Returned Checks will be charged a $30 fee in addition to any balance due, and must be picked up at our office within 3 days of notification. Any unresolved bad checks will be prosecuted.

A deposit of 1/2 of fees for crowns, bridges and major dental work is due the day the treatment is started. The balance is due prior to placement of any crowns, bridges or major dental work.

Fees for extractions are due before the extraction is done.

As a courtesy our office staff will process all insurance claims, however we do not accept responsibility for the outcome from your insurance provider, and filing your insurance claims does not relieve you of your financial responsibility for our fees. Any co-payments or deductible amounts must be paid before treatment is started. If after 60 days your insurance company has not paid our office, you will be billed personally. A co-payment is only an estimate of charges. A balance may be due following insurance payment. I understand I am responsible for any balances due.

I have read and understand the financial policies set forth above.

Signature____ Date ____________________

Print Name ____

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Signature____________________________________ Date __________________

Print Name ____

Appointment Cancellation Policy

"It is not the purpose of our no-show policy to profit from patient's tardiness/absence. The purpose is the patient understands that time at ***Chesemore Dental*** *is valuable and we have a commitment to all our patients to perform timely and effective dental treatment. When a patient does not show up for their appointment, they inhibit other patients from filling that vacancy."*

No Show Policy

- 1st No show: No Penalty, follow-up call or text from staff.
- 2nd No show: $35 no show penalty. No follow-up call or text from staff.
- 3rd No show: $50 no show penalty. Patient no longer scheduled. If patient wants to return to practice for treatment they will need to schedule office visit with Dentist.

We understand things happen unexpectedly. Family emergencies are tolerated, no shows will not count against the patients as long as the patient describes the situation.

Same Day Cancellation:

- *Cancellations made less than 24 hrs in advance will be considered a 'No Show' for the appointment*

15 minutes late for appointment:

- *Once Patient is 15 min past due for appointment, it is at the dentist's discretion if they will or will not be seen that day*

Patient's Signature:______________________________ Date:__________

Dentist's Signature:______________________________ Date:__________