Dental Arts *of* Tellico Village

# New Patient Letter

## Welcome to Dental Arts of Tellico Village!

Thank you for contacting us to schedule your dental care. Following is a review of our fees, office policies and procedures. Radiographs will be taken at your initial examination to facilitate accurate diagnosis. Current radiographs may be requested from your previous dentist. I will review your care and answer all your questions at this examination. Recommended treatment may be scheduled with either myself or Dr. John.

| | | |
|---|---|---|
| Initial Exam | $132.00 | (Periodic exams are $63.00) |
| Bitewing X-rays | $99.00 | (Routinely done once a year) |
| 3-D Panorex X-rays | $218.00 | (Routinely done every 3 years) |
| **TOTAL:** | **$449.00** | **(If all procedures are done at this appointment)** |

Registered Dental Hygienists will perform preventive care. Preventive treatment includes routine cleaning and fluoride. Periodontal treatment is available when necessary.

| | | |
|---|---|---|
| Perio Prophylaxis | $166.00 | (Suggested four a year) |
| Prophylaxis | $122.00 | (Routine cleanings are suggested twice a year) |
| Fluoride | $54.00 | (Suggested for adults as well as children) |

All fees are payable at the time of service unless you have dental insurance. As a courtesy, our office will file your insurance claim. The estimated balance not covered by your policy is payable at the time of service. If there is a delay in receipt of the insurance payment which exceeds 60 days, the balance due is your responsibility. When the insurance payment is received, you will be refunded the credit balance.

Appointments are carefully scheduled to reserve the necessary time for your procedure. Except in unusual circumstances, your appointment will be at the arranged hour. We realize that your time, as well as the doctor's, is valuable. Therefore, except in an emergency, please avoid canceling your appointment. Should it be necessary to cancel or reschedule, please allow 24 hours advance notice. This gives the staff time to contact someone on our waiting list.

**PLEASE NOTE:** Failure to return completed paperwork to our office **5 business days** prior to your appointment date **WILL** result in the rescheduling of your initial comprehensive exam appointment.

**Office hours:** Monday–Thursday 8:00am to 5:00pm

**Office phone:** 865-458-4869

You may email or fax paperwork to **office@TellicoDentalArts.com** or **865-458-4735**.

If you have any questions or concerns, please call. We will be happy to help you. Our entire staff strives to make your dental experience pleasant.

Sincerely,

**Angela K. Burns, D.D.S.**

Angela K. Burns, D.D.S.

Dental Arts *of* Tellico Village

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| | | |
|---|---|---|
| Child's Initial Exam | $74.00 | (Periodic exams are $55.00) |
| Bitewing X-rays | $71.00 | (Routinely done once a year) |
| Panorex X-rays | $181.00 | (Routinely done every 3 years) |
| **TOTAL:** | **$326.00** | **(If all procedures are done at this appointment)** |

Registered Dental Hygienists will perform preventive care. Preventive treatment includes routine cleaning and fluoride. Periodontal treatment is available when necessary.

| | | |
|---|---|---|
| Prophylaxis | $90.00 | (Routine cleanings are suggested twice a year) |
| Fluoride | $38.00 | (Suggested for adults as well as children) |

All fees are payable at the time of service unless you have dental insurance. As a courtesy, our office will file your insurance claim. The estimated balance not covered by your policy is payable at the time of service. If there is a delay in receipt of the insurance payment which exceeds 60 days, the balance due is your responsibility. When the insurance payment is received, you will be refunded the credit balance.

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Sincerely,

**Angela K. Burns, D.D.S.**

Angela K. Burns, D.D.S.

**Dental Arts**
*of* **Tellico Village**

# Welcome

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

Patient Number

Age ______ Today's Date ______________

## Patient Information

Last Name ______________________________ First Name ______________________ Initial ______

Date of Birth ________________ ☐ Male ☐Female If child: parent's name ________________________

How do you wish to be addressed? ______________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Home Address Line 1 ___________________________________ Line 2 ________________________

City ______________________________________________ State __________ Zip __________

Work Address Line 1 ___________________________________ Line 2 ________________________

City ______________________________________________ State __________ Zip __________

Home Phone ______________________________ Work Phone ______________________________

Fax ____________________________________ Cell Phone ______________________________

Email ____________________________________________________________________________

Patient / Parent Employed By _____________________________________________________

Present Position ___________________________ How long held ___________________________

Spouse / Parent Name ______________________________________________________________

Present Position ___________________________ How long held ___________________________

Responsible Party __________________________ Drivers License Number___________________

Method of Payment: ☐ Insurance ☐ Cash ☐ Credit Card

Purpose of Call ___________________________________________________________________

Other Family Members in this Practice ______________________________________________

Whom may we thank for this referral? ______________________________________________

Patient SS# ________________________________ Spouse / Parent SS# ______________________

Someone to notify in case of emergency not living with you _________________________

### Dental Insurance 1st Coverage

Employee Name ____________________ DOB __________

Relationship to Patient ____________________________

Employer Name ____________________ Years __________

Insurance Company ________________________________

Address _________________________________________

_________________________________________________

Telephone _______________________________________

Program / Policy # ________________________________

SS# _____________________________________________

Union Local or Group ______________________________

### Dental Insurance 2nd Coverage

Employee Name ____________________ DOB __________

Relationship to Patient ____________________________

Employer Name ____________________ Years __________

Insurance Company ________________________________

Address _________________________________________

_________________________________________________

Telephone _______________________________________

Program / Policy # ________________________________

SS# _____________________________________________

Union Local or Group ______________________________

Dental Arts *of* Tellico Village

# Medical History

Patient Number

Name ______________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________

Date of your most recent physical exam ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Do you have or have you ever had:** (Yes / No)

1. hospitalization for illness or injury ☐ ☐
2. an allergic or bad reaction to any of the following ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ chlorhexidine (CHX)
   - ☐ metals *(nickel, gold, Silver)* ______
   - ☐ Iodine
   - ☐ latex ______
   - ☐ nuts ______
   - ☐ fruit ______
   - ☐ milk ______
   - ☐ red dye ______
   - ☐ other ______
3. heart problems, or cardiac stent within the last six months ☐ ☐
4. history of infective endocarditis ☐ ☐
5. artificial heart valve, repaired heart defect *(PFO)* ☐ ☐
6. pacemaker or implantable defibrillator ☐ ☐
7. orthopedic or soft-tissue implant *(e.g. joint replacement, breast implant)* ☐ ☐
8. heart murmur, rheumatic or scarlet fever ☐ ☐
9. high or low blood pressure ☐ ☐
10. a stroke *(taking blood thinners)* ☐ ☐
11. anemia or other blood disorder ☐ ☐
12. prolonged bleeding due to a slight cut *(or INR > 3.5)* ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox ☐ ☐
15. breathing problems *(e.g. asthma, stuffy nose, sinus congestion)* ☐ ☐
16. sleep problems *(e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting)* ☐ ☐
17. kidney disease ☐ ☐
18. liver disease or jaundice ☐ ☐
19. vertigo *(e.g. "the room is spinning")* ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ☐ ☐
21. hormone deficiency or imbalance *(e.g. poly cystic ovarian syndrome)* ☐ ☐
22. high cholesterol or taking statin drugs ☐ ☐
23. diabetes *(HbA1c=_____ )* ☐ ☐
24. stomach or duodenal ulcer ☐ ☐
25. Digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) ☐ ☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications ☐ ☐ *(e.g. taking bisphosphonates)*
27. arthritis or gout ☐ ☐
28. autoimmune disease *(e.g. rheumatoid arthritis, lupus, scleroderma)* ☐ ☐
29. glaucoma ☐ ☐
30. contact lenses ☐ ☐
31. head or neck injuries ☐ ☐
32. epilepsy, convulsions *(seizures)* ☐ ☐
33. neurologic disorders *(e.g., Alzheimer's disease, dementia, prion disease)* ☐ ☐
34. viral infections (e.g., cold stones) bacterial infections (e.g., lyme disease) ☐ ☐
35. any lumps or swelling in the mouth ☐ ☐
36. hives, skin rash, hay fever ☐ ☐
37. STI / STD / HPV ☐ ☐
38. hepatitis (type ___) ☐ ☐
39. HIV / AIDS ☐ ☐
40. tumor, abnormal growth ☐ ☐
41. radiation therapy ☐ ☐
42. chemotherapy, immunosuppressive medication ☐ ☐
43. emotional difficulties ☐ ☐
44. psychiatric treatment, antidepressant, mood stabilizing medication ☐ ☐
45. concentration problems or ADD/ADHD ☐ ☐
46. alcohol / recreational drug use ☐ ☐

**Are You:** (Yes / No)

47. presently being treated for any other illness ☐ ☐
48. aware of a change in your health in the last 24 hours ☐ ☐ *(e.g. fever, chills, new cough, or diarrhea)*
49. taking medication for weight management ☐ ☐
50. taking dietary supplements ☐ ☐
51. often exhausted or fatigued ☐ ☐
52. experiencing frequent headaches or chronic pain ☐ ☐
53. a smoker, smoked previously, or use smokeless tobacco ☐ ☐
54. considered a touchy / sensitive person ☐ ☐
55. often unhappy or depressed ☐ ☐
56. taking birth control pills ☐ ☐
57. currently pregnant ☐ ☐
58. diagnosed with a prostate disorder ☐ ☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment. (i.e. BOTOX®, Collagen Injections)

______________

List all medications, supplements, and or vitamins taken within the last two years.

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient Signature ______________ Date ________

Doctor Signature ______________ Date ________

Dental Arts
*of* Tellico Village

# Dental History

Patient Number

Name ______ Nickname ______ Referred By ______

Age ______ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist ______ How long have you been a patient? ______ Months / Years

Date of the most recent dental exam ______ Date of the most recent dental X-rays ______

Date of most recent treatment (other than cleaning) ______ Purpose ______

I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

What is your immediate concern? ______

## Personal History

| # | Question | Yes | No |
|---|---|---|---|
| 1. | Are you fearful of dental treatment? How fearful, on a scale from 1 (least) to 10 (most)? ______ | ☐ | ☐ |
| 2. | Have you had an unfavorable dental experience? | ☐ | ☐ |
| 3. | Have you ever had complications from past dental treatment? | ☐ | ☐ |
| 4. | Have you ever had trouble getting numb or had any reactions to local anesthetic? | ☐ | ☐ |
| 5. | Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ______ | ☐ | ☐ |
| 6. | Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? | ☐ | ☐ |

## Gum and Bone

| # | Question | Yes | No |
|---|---|---|---|
| 7. | Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? | ☐ | ☐ |
| 8. | Have you ever had or been told you have gum loss, gum disease or bone loss between your teeth? | ☐ | ☐ |
| 9. | Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? | ☐ | ☐ |
| 10. | Is there anyone with a history of periodontal disease in your family? | ☐ | ☐ |
| 11. | Have you ever experienced gum recession, or can you see more of the roots of your teeth? | ☐ | ☐ |
| 12. | Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? | ☐ | ☐ |
| 13. | Have you experienced a burning, painful sensation or metallic taste in your mouth? | ☐ | ☐ |

## Tooth Structure

| # | Question | Yes | No |
|---|---|---|---|
| 14. | Have you had any cavities within the past 3 years? | ☐ | ☐ |
| 15. | Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing ir chewing any food? | ☐ | ☐ |
| 16. | Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? | ☐ | ☐ |
| 17. | Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? | ☐ | ☐ |
| 18. | Do you have grooves or notches on your teeth near the gum line? | ☐ | ☐ |
| 19. | Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | ☐ | ☐ |
| 20. | Do you frequently get food caught between any teeth? | ☐ | ☐ |

## Bite and Jaw Joint

| # | Question | Yes | No |
|---|---|---|---|
| 21. | Does your jaw joint ever have pain, sounds (popping, cracking) or experience limited opening or locking? | ☐ | ☐ |
| 22. | Do you feel like your need to pull your lower jaw back? | ☐ | ☐ |
| 23. | Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | ☐ | ☐ |
| 24. | In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? | ☐ | ☐ |
| 25. | Are your teeth becoming more crooked, crowded, or overlapped? | ☐ | ☐ |
| 26. | Are your teeth developing spaces or becoming more loose? | ☐ | ☐ |
| 27. | Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? | ☐ | ☐ |
| 28. | Do you place your tongue between your teeth or close your teeth against your tongue? | ☐ | ☐ |
| 29. | Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | ☐ | ☐ |
| 30. | Do you clench or grind your teeth together in the daytime / nighttime or even make them sore? | ☐ | ☐ |
| 31. | Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? | ☐ | ☐ |
| 32. | Do you wear or have you ever worn a bite appliance? | ☐ | ☐ |

## Smile Characteristics

| # | Question | Yes | No |
|---|---|---|---|
| 33. | Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? | ☐ | ☐ |
| 34. | Have you ever bleached (whitened)your teeth? | ☐ | ☐ |
| 35. | Have you felt uncomfortable or self conscious about the appearance of your teeth? | ☐ | ☐ |
| 36. | Have you been disappointed with the appearance of previous dental work? | ☐ | ☐ |

Patient Signature ______ Date ______

Doctor Signature ______ Date ______

# DENTAL ARTS of TELLICO VILLAGE

220 Village Square
Loudon, Tn 37774

## CONSENT

I, ______________________________, consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following person or people who are involved in my care (or my child's care) or payment for that care.

______________________________________________________________

______________________________________________________________

______________________________________________________________

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. If an unpaid account balance is sent to a collection agency, the collection agency fee will be added to the balance owed, and the patient's responsibility to pay.

I attest to the accuracy of the information on this page.

______________________________ ______________________

Patient or Guardian's Signature Date