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	$137.00	(Periodic exams are $66.00)
Bitewing X-rays	$103.00	(Routinely done once a year)
3-D Panorex X-rays	$227.00	(Routinely done every 3 years)
TOTAL:	**$467.00**	**(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	$173.00	(Suggested four a year)
Prophylaxis	$127.00	(Routine cleanings are suggested twice a year)
Fluoride	$56.00	(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

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 _____

Angela K. Burns, D.D.S. | 220 Village Square, Loudon, TN 37774 | Office: 865-458-4869 | Fax: 865-458-4735 | TellicoDentalArts.com

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

		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

		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

		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

		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

		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 _____

Angela K. Burns, D.D.S. | 220 Village Square, Loudon, TN 37774 | Office: 865-458-4869 | Fax: 865-458-4735 | TellicoDentalArts.com

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