WELCOME TO
TATUM DENTISTRY

Patient Information (confidential)

Today's Date _____ / _____ / _____

Name _____ Male_____ Female_____

Address _____

City _____ State _____ Zip _____ Single _____ Married _____

Date of Birth _____ / _____ / _____ Your Occupation _____

Best Email _____ SS# _____ - _____ - _____

Cell Phone _____ / _____ / _____ Do you receive text messages? Y / N

Home Phone _____ / _____ / _____

Work Phone _____ / _____ / _____

Best way to communicate with you? Cell _____ Home _____ Email _____ Work _____ Text _____

Whom may we thank for referring you, we would like to send them a gift card? _____

If you are under 18 years of age, Parent/Guardian's Name _____

Parent/Guardian's Employer _____

Parent/Guardian's Occupation _____

Parent/Guardian's Work Phone _____ / _____ / _____

Tatum Dentistry CHARLESTON SC

Insurance Information

Name of Policy Holder _____

Policy Holder's Date of Birth _____/_____/_____ Policy Holder's SS# _____ - _____ - _____

Address of Insured (if different from patient) _____

Policy Holder's Employer _____

Insurance Company _____

Insurance Company Address _____ City/State/Zip _____

Patient Dental History

Why are you here today? _____

If you could change anything about your smile, what would it be? _____

Do you use a Sonic toothbrush?	Yes or No _____
Do your gums bleed while brushing or flossing?	Yes or No _____
Are your teeth sensitive to hot or cold liquids/foods?	Yes or No _____
Are your teeth sensitive to sweet or sour liquids/foods?	Yes or No _____
Do you feel pain to any of your teeth?	Yes or No _____
Do you have any sores or lumps in or near your mouth?	Yes or No _____
Have you had head, neck, or jaw injuries?	Yes or No _____
Have you ever experienced any of the following problems in your jaw?	
Clicking	Yes or No _____
Pain (joint, ear, side of face)	Yes or No _____
Difficulty in opening or closing	Yes or No _____
Difficulty in chewing	Yes or No _____
Do you have frequent headaches?	Yes or No _____
Do you clench or grind your teeth?	Yes or No _____
Do you bite your lips or cheeks frequently?	Yes or No _____
Have you ever had any difficult extractions in the past?	Yes or No _____
Have you ever had any prolonged bleeding following extractions?	Yes or No _____
Have you had any orthodontic or Invisalign treatment?	Yes or No _____
Do you wear dentures or partials?	Yes or No _____
If yes, how long have you had the appliances? _____	
Have you ever been taught how to properly brush and floss?	Yes or No _____
Do you have anxiety about coming to the dentist?	Yes or No _____

Students

School/College _____ City/State _____

Attend: Full time_____ Part time_____ Verification of Student Status (Student I.D.) Yes_____ No_____

(If yes, please present ID to photocopy for our records)

Patient Medical History

List your allergies (medicine, metals, latex etc..) _____

List your medications: _____

Are you taking medicine for osteoporosis? Yes or No_____

Do you take antibiotics before dental treatment for any reason (heart murmur, transplant surgery, etc...)? Yes or No_____

Physician _____ Are you pregnant? Yes or No_____ If so, how many weeks? _____

Are you under medical treatment now? Yes or No_____ Describe: _____

Do you like to use laughing gas (N_2O/O_2) during dental treatment? Yes or No_____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes or No_____

If yes, please explain: _____

Do you use tobacco? Yes or No_____ Do you use controlled substances? Yes or No_____ Details: _____

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

High Blood Pressure	Yes or No_____	ADD/ADHD	Yes or No_____
Heart Attack	Yes or No_____	Anemia	Yes or No_____
Rheumatic Fever	Yes or No_____	Emphysema	Yes or No_____
Swollen Ankles	Yes or No_____	Cancer	Yes or No_____
Fainting /Seizures	Yes or No_____	Arthritis	Yes or No_____
Asthma	Yes or No_____	Joint Replacement or Implant	Yes or No_____
Low Blood Pressure	Yes or No_____	Hepatitis /Jandice	Yes or No_____
Epilepsy/Convulsions	Yes or No_____	Stomach Ulcers	Yes or No_____
Leukemia	Yes or No_____	Chest Pains	Yes or No_____
Diabetes	Yes or No_____	Stroke	Yes or No_____
Kidney Diseases	Yes or No_____	Tuberculosis	Yes or No_____
AIDS or HIV Infection	Yes or No_____	Radiation Therapy	Yes or No_____
Thyroid Problem	Yes or No_____	Glaucoma	Yes or No_____
Heart Disease	Yes or No_____	Liver Disease	Yes or No_____
Cardiac Pacemaker	Yes or No_____	Heart Trouble	Yes or No_____
Heart Murmur	Yes or No_____	Respiratory Problems	Yes or No_____
Angina	Yes or No_____	Mitral Valve Prolapse	Yes or No_____

*Are there any other medical conditions you have that Dr. Tatum needs to know about? _____

_____

Authorization and Release

I understand that the information that I have given today is correct to the best of my knowledge.I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of Patient (or parent/guardian) _____ Date _____

Notice Of Privacy Practices

This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above (a copy of this has been provided to you).

Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Signature _____ Date _____

Consent for Use and Disclosure of Health Information

In cases where Tatum Dentistry has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

Signature _____ Date _____

FINANCIAL ARRANGEMENTS AND YOUR DENTAL INSURANCE

(A copy of this has been provided to you)

Dr. Tatum and her staff are committed to providing you with the best dental care and service possible. If you have dental insurance we will be pleased to assist you in receiving your maximum allowable benefits. To achieve these goals we need your assistance in establishing your financial arrangements with Dr. Tatum. **Payment is due at the time services are rendered**; after your visit we will be pleased to assist you in processing your claim and seeking your reimbursement.

The ultimate responsibility for the fees for services rendered is the patient's. Patient Initials Here _____

Dr. Tatum and the members of the Clinical Staff will gladly discuss your proposed treatment plan. The members of the Administrative Staff will gladly answer any questions they can about your dental insurance. However, as the patient you must realize the following:

1. **The insurance you have is a contract between your employer, the insurance company and yourself.**
2. **Your employer has selected the level of insurance coverage you have. Covered services vary from plan to plan.**

As we enter into our partnership, we emphasize the importance of keeping your reserved appointment time so that we can provide you with the best care and treatment possible. We will make every effort to reschedule those of you who must change your appointment and provide us with 48 hours notice. It is our custom though, to assess a fee of $75 for last minute cancellation and missed appointments. We will consider exceptions on an individual basis. For your convenience you may pay your bill by cash, check, Visa, MasterCard, American Express, Discover or through a Care Credit financing package. If you have any questions please do not hesitate to ask. We are here to assist you and look forward to establishing a long-standing relationship.

Printed Name _____ **Patient or Guardian Signature** _____ **Date** _____

Tatum Dentistry