Dr. Frederick H. Thompson, DDS

4109 Mountain View Ave, Suite #300
Chattanooga, TN 37415
Phone: 423-875-5661

MountainView Family Dental

We sincerely thank you for choosing our practice for your dental needs, Our goal is for every dental visit to be the best it can possibly be, We are always accepting new patients, and we look forward to seeing any friends or family you refer to our office.

Please, let us know if you need assistance completing this form

Patient Information

Date:_____ Name: (Last)_____ (First) _____ (Middle)_____

Date of Birth_____ Sex:_____ Marital Status:_____ Nickname: _____

Age _____ Social Security Number _____ Driver's License No: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: Street _____ City _____ State _____ Zip _____

Employer Name: _____Occupation _____ Employer Phone:_____

How did you hear about our office? _____ Email Address:_____

How would you like to be contacted? ❑ Home ❑ Work ❑ Cell ❑ Email Mobile Carrier:_____

Emergency Contact Name and Phone Number: _____

Billing Information (If Different from Patient Information)

If patient is a minor, list parent or guardian's information here

Name: (Last)_____(First) _____ (Middle)_____ Date of Birth_____

Social Security Number_____ Driver's License Number_____ Marital Status_____

Address: Street _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone: _____

Employer Address_____

Email Address: _____

Primary Dental Insurance

Insured's Full Name _____ Date of Birth:_____ Marital Status:_____

Address: Street _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insured's ID, or Social Security Number_____ Relationship to Patient _____

Employer Name: _____ Full Time ☐ Part Time ☐ Retired ☐

Insurance Company Name: _____ Group Number: _____

Insurance Company Phone Number_____

Insurance Company Address:_____

Does Patient have Secondary Dental Insurance Coverage: Yes ☐ No ☐

If yes, please notify patient coordinator upon competition of this form.

Please continue on back of this Page

Financial Agreement

Please read the following

Payment for services rendered by Dr. Frederick Thompson is the sole responsibility of the patient or legal guardian. Payment is due upon receipt of services. All charges not covered by Insurance are the responsibility of the patient /guardian. We no longer accept assignment of secondary dental insurance towards payment We will fill out the forms to allow reimbursement to the patient. If there is any default in payment for services, the patient or guardian agrees to be responsible for any costs necessary to collect this debt. (Court Costs, Collection Fees, Attorney Fees, etc.).

Initial:_____

Dental Insurance

If you have dental insurance

As a courtesy, we accept payment from most insurance companies and will file your dental claim on your behalf. We will estimate your deductible, and any portion not covered by your insurance, and that amount is due at the time services are rendered. Our estimates may differ from your insurance company's calculations. I understand that insurance estimates are not a guarantee of coverage. Any amounts not paid by insurance, are the guarantor's responsibility.

By signing below, I acknowledge that all services rendered will be charged directly to me and I am ultimately responsible for my account regardless of my insurance coverage.

Initial:_____

Assignment and Release

I hereby authorize payment directly to MountainView Family Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered to me, or my dependants.

I authorize the above doctor and/or provider or supplier of the services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Initial:_____

Photography Release

I _____, hereby authorize MountainView Family Dental to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth for my records and patient care.

On occasion photographs, slides, and or videos are used in publications, or as part of a demonstration. My name or other identifying informations will be kept confidential.
I do not expect compensation, financial or otherwise, for these photographs.

Initial:_____

Printed Name of Responsible Party:_____

Signature of Responsible Party:_____ **Date:**_____

Today's Date:_____ **Patient Name:**_____ **Age:**_____ **Date of Birth:**_____

Health History Information

Have you ever used bone loss prevention drugs (biphosphonates) such as Fosomax, Actonel, or Boniva?
Yes ☐ No ☐ List: _____

Are you currently taking any blood thinners, including aspirin:
Yes ☐ No ☐ List: _____

Have you had any joint replacement surgery?
Yes ☐ No ☐ List: _____

Have you had any stints placed in your body?
Yes ☐ No ☐ List: _____

Do you have any orthopedic pins, plates, or screws in any part of your body?
Yes ☐ No ☐ List: _____

Have you ever been told that you need to pre-medicate with antibiotics for dental treatment? Yes ☐ No ☐
If yes, what has been prescribed? _____

Do you currently, or have you previously, smoked or used tobacco products? Yes ☐ No ☐
If yes, how long ago? _____

Do you currently, or have you previously, used recreational drugs? Yes ☐ No ☐
If yes, how long ago? _____

If female, are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐ On birth control? Yes ☐ No ☐

Dental History

Name of previous dentist: _____

Date of last cleaning or exam: _____

Have you ever had orthodontics, periodontal surgery, or other major dental treatment? Yes ☐ No ☐

Explain: _____

_____

Do you have any areas where food impacts around your teeth? Yes ☐ No ☐

Do your gums tend to bleed easily, feel irritated, or feel tender? Yes ☐ No ☐

Are you sensitive to hot, cold, pressures, or sweets? Yes ☐ No ☐

Do you have popping, clicking, or other noises in your jaw joints? Yes ☐ No ☐

Are you aware of grinding or clenching your teeth? Yes ☐ No ☐

Have you ever had any negative reactions to a dental injection or nitrous oxide? Yes ☐ No ☐

Are you anxious or nervous about dental treatment? Yes ☐ No ☐

Is there anything, not listed on this form, that you feel we should know about your medical or dental history?

_____

_____

_____

List any items you wish to discuss with your dentist today.

_____

_____

Please continue on back of this Page

Complete The Following

Y	N	Conditions
☐	☐	Anemia
☐	☐	Arthritis, Rheumatism
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Bleeding Abnormally, W/Extractions
☐	☐	Blood Disease
☐	☐	Cancer Type_____
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Chronic Fatigue Syndrome
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Lesions
☐	☐	Cortisone Treatments
☐	☐	Cough: Persistent or Bloody
☐	☐	Diabetes Type_____
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells or Dizziness
☐	☐	Glaucoma
☐	☐	HIV+AIDS

Y	N	Conditions
☐	☐	Headaches
☐	☐	Heart Murmur
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaw Pain
☐	☐	Joint Replacement
☐	☐	Kidney Disease
☐	☐	Latex Sensitivity
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Care
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Stroke
☐	☐	Swollen Neck
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Tumor or Growth on Head/Neck
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Osteoporosis Med (IV/Oral) Fosomax

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other: _____

Medications

List all medications here. Include all prescriptions, over the counter medications, vitamins, and herbs.

_____

_____

_____

_____

_____

_____

* Printed name:_____ Signature:_____ Date:_____

Office Use Only

_____

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