Moss Dentistry, LLC
1916 E. Lamar Alexander Parkway
Maryville, TN 37804
865-983-4642

Welcome to Moss Family Dentistry!

We are very glad you have chosen us to take care of your oral health. We are excited to have you be a part of our practice. We look forward to helping you achieve and maintain a beautiful, healthy smile.

Your First Visit

Our goal for your first visit is to perform a comprehensive exam to evaluate your overall dental health. This will likely involve several x-rays to check for cavities and an examination of your gums to determine what type of cleaning you should have. We will also need to review your medical history, including any medications you take and any past illnesses or surgeries. This is to help ensure we are able to recommend the best possible care for you. If you have X-rays taken at another office within the last year, please let us know, as we can probably acquire them.

Appointments

To ensure we are able to see all our patients in a timely fashion we ask that you please provide notice of cancellation 24 hours prior to your appointment.

Office Hours: Monday, Tuesday, and Thursday: 8:00am – 5:00pm. Friday: 8:00am – 4:00pm

Privacy Practices

A copy of our privacy practices can be made available for you at your request. Please ask the front desk if you would like to review a copy.

Your Medical History

Please fill out the provided history completely. Make sure to include any major illnesses, injuries, or surgeries you have had. There is space provided to list additional medical conditions that may not be included in our form's checklist. Please also provide us with the names and dosages of any medications you may be taking. This information is important to help us select the best treatment and most appropriate medications to prescribe for you.

Dental Insurance

If you have dental insurance, we will gladly file your claim for you. We will also try to estimate what portion of your fees will be covered by your insurance. However, we cannot guarantee these estimates and the ultimate decision is made by your insurance. To eliminate any confusion about insurance coverage, we may have the insurance provide us with a predetermination of your benefits prior to starting major treatment. We work hard to get your insurance to help cover the cost of your treatment, but sometimes insurance simply will not cover everything that is needed for optimal care.

Financial Arrangements

We are committed to making sure you are able to receive the treatment we recommend. Understanding that each of us has unique financial needs we are happy to offer payment options to fit into your budget. We offer a 5% discount for any treatment over $500 that is paid in full the day of service or earlier. We also partner with CareCredit, a company that can finance your treatment for you and offer interest free payments for several months. If you are interested in CareCredit please ask for a pamphlet detailing their payment plans.

Moss Family Dentistry
Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient Information:

Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____email Address: _____
May we contact you by email to confirm appointments? ☐ Yes ☐ No
Would you like to receive a newsletter by email? ☐ Yes ☐ No
Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced
☐Separated ☐Widowed
Birth Date: _____ Age: _____ Social Security #: _____
Employment Status: ☐Full Time ☐Part Time ☐Retired
Occupation: _____
Employer: _____

Responsible Party Information (If someone other than Patient):

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____email Address: _____
Birth Date: _____ Age: _____ Social Security #: _____
Employer: _____
☐ Responsible Party is also a Policy Holder for Patient
☐ Primary Policy Holder
☐ Secondary Policy Holder

Primary Insurance Information:

Name of Insured: _____
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Social Security #: _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____	Insurance Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____

How Did You Hear About Us?
☐ Referred by another patient. Who can we thank? _____
☐ Website
☐ Other

Please list any prior difficulties or problems you have had at the dentist so we can make your experience with us more comfortable.
_____
_____
_____
_____
_____

Are you interested in exploring your options for any of the following treatments?
☐ Cosmetic Dentistry
☐ Tooth Whitening
☐ Invisalign Orthodontics for tooth straightening
☐ Snoring Treatment

Time 12:10 PM | Dr. Whittaker Moss | Date 1/19/2016

Moss Family Dentistry Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.
Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive.
Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Do you see any other physicians?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Operations and Surgery

Have you ever been hospitalized? ○ Yes ○ No

Have you ever had surgery? ○ Yes ○ No

Please summarize:

Medications

Do you take any medications, pills, or drugs? ○ Yes ○ No

Please list them:

Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other allergy

Please list any other allergies:

Do you snore?	○ Yes ○ No
Have you ever been diagnosed with sleep apnea?	○ Yes ○ No
Do you ever gasp for air in your sleep?	○ Yes ○ No
Have you ever been told that you stop breathing while sleeping?	○ Yes ○ No
Have you ever used a CPAP?	○ Yes ○ No
Would you be interested in alternatives to CPAP?	○ Yes ○ No

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No	Cancer ○ Yes ○ No
Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No	Chemotherapy ○ Yes ○ No
Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No	Chest Pains ○ Yes ○ No
Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No	Cold Sores/Fever Blisters ○ Yes ○ No
Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No
Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No	Convulsions ○ Yes ○ No
Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed? ○ Yes ○ No

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Moss Dentistry, LLC

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party providers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____