BACK TO BASICS
DENTISTRY

New Patient Registration

Patient Information:

Patient First and Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient is: ○ Policy Holder
○ Responsible Party

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ ○ Text ○ Email ○ Both

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ SSN: _____ Driver's License: _____

Emergency Contact: _____ Relation: _____

Phone #: _____ Referred by: _____

Insurance Information:

Policy Holder: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Policy Holder DOB: _____ Policy Holder SSN: _____

Employer: _____ Insurance Company: _____

Member/Subscriber ID: _____

Dental Questionnaire:

Date of Last Dental Exam: _____ Date of Last Dental Cleaning: _____

Are you experiencing any pain/sensitivity with your teeth? ○ Yes ○ No If **yes**, for how long? _____

Have you tried anything to help with the pain/sensitivity? ○ Yes ○ No If **yes**, is it working? _____

Do you have any specific dental concerns today? _____

What do you want to focus on today? _____

On a scale of **1-10**, with 10 being the best, how would you rate your overall smile and condition of your teeth? _____

What would you like them to be? _____

Please circle if you have had any of the following:

Bad breath	Food collection in between teeth	Sensitivity to sweets
Bleeding gums	Grinding of teeth	Orthodontic treatment
Blisters on gums or lips	Swollen or tender gums	Periodontal treatment
Burning sensation with tongue	Loose teeth	Gum surgery
Chewing on fingernails or objects	Broken fillings	Sensitivity to cold
Clicking or popping in your jaw	Sensitivity to hot	Dry mouth

How often do you brush? _____ **How often do you floss?** _____

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Acknowledgment of Office Policies

_____ I hereby authorize the release of any information necessary to process an insurance claim and request direct payment to Back to Basics Dental Center.

_____ Fees are to be paid at the time services are performed.

_____ It is my responsibility to understand my dental insurance. Back 2 Basics Dentistry is only given an estimate of my coverage through my insurance company. I am responsible for any balance my insurance does not pay.

_____ Our dentists base treatment recommendations on your needs, not what your insurance covers.

_____ If I require a procedure that require two or more hours, I will be asked to put a deposit of $100 that will go towards my dental procedure.

_____ Based on Tennessee State Law, children under the age of 18 must be accompanied by a parent or legal guardian to ALL dental appointments.

_____ I understand that children should not be brought with an adult when the adult has the scheduled appointment. It is not in the best interest of the child, the adult patient, nor our staff.

_____ I understand that if I am over 18 years old any issues regarding my treatment and or my account cannot be discussed with family members or friends unless I specify in writing. All other communications will be in accordance with the HIPPA guidelines. (Please ask the Patient Coordinator for more information if you wish to add your spouse or family members)

_____ Under normal circumstances, dental work completed in our office is guaranteed for one year providing that I take appropriate care of my mouth, received regular six-month checkups, and have regular cleanings.

_____ I understand that my dental record information belongs to me but my dental records, radiographs, photos, and study models are the property of Back to Basics Dental Center, LLC. If I request dental records, I am aware there will be a standard fee of $20 for these records.

_____ I understand that if a check written for my account to Back to Basics Dental Center is returned for insufficient funds, a returned check fee of $30 will be added to the original balance of my check and I am responsible for paying this amount prior to any further dental appointments.

_____ I understand that should my account balance not be paid in a timely manner; it will be turned over to our collection agency. I will be responsible for any billing, finance, legal or collection fees, which may occur.

_____ I understand that I may be charged $60 for appointments cancelled with less than 24 hours' notice prior to my next visit except in the case of emergencies or serious illness. I understand that I will not be given any other dental appointments until this balance is paid. I further understand that my insurance company will not pay for this charge.

_____ I understand that if I miss three (3) appointments without 24 hours' notice of cancellation, I may be discharged from the practice.

Printed Name _____ Signature _____

Date _____ Witness _____

BACK TO BASICS
DENTISTRY

1762 Highway 48
Clarksville, TN 37040
931-645-8000

Photo, Video, & Recording Release

Name: _____

Date: _____

I hereby

- ○ Authorize
- ○ Do NOT authorize

The use and reproduction by Back to Basics Dental Center, LLC, DBA Back 2 Basics Dentistry, of all photographs and/or videos which have been taken of me without further compensation to me. All negatives, positives, digital files, etc. shall constitute property of Back 2 Basics Dentistry solely and completely. To ensure the highest level of accuracy in your medical records and to allow your provider to focus entirely on your care during your visit, our practice utilizes digital recording technology (including automated/AI scribing tools) to assist in capturing clinical documentation and generating chart notes.

Signature _____

BACK TO BASICS
DENTISTRY

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Back 2 Basics Dentistry. I hereby authorize, as indicated by my signature below, Back 2 Basics Dentistry, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

- ○ You may contact me at my home telephone number _____
- ○ You may contact me on my mobile telephone number _____
- ○ You may contact me on my work telephone number _____
- ○ You may send me an email at: _____
- ○ Other _____

Please list authorized persons with whome we may discuss your Protected Health Information (PHI). Please notify us if you desire to removed a name from this list in the future.

1._____ Date _____ Relationship: _____

2._____ Date _____ Relationship: _____

3._____ Date _____ Relationship: _____

4._____ Date _____ Relationship: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining the acknowledgement
- ○ Other (please Specify): _____

Staff Initials: _____

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PATIENT CONSENT

Clinical

1. I authorize **BACK TO BASICS DENTAL CENTER, LLC.,** to perform all recommended treatment.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be release to third-party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardia arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.8% MPR will be automatically tabulated into my account if my balance is 30 days old or older. I will also have a $2.00 per month billing charge of $2.00. Should my account become delinquent, I will be responsible for all additional collection costs which could be up to 35% of your outstanding balance, including reasonable attorney fees.
5. A $60 per hour missed appointment fee will be charged to my account for all missed appointments or last-minute cancellations by me. I am aware that to hold down operating costs, 24 hours' notice of cancellation is required.

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers, or their representatives, all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name lists as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____

If the patient is a child, please provide the parental or legal guardian's consent:

NOTE (MINORS): The parent or legal guardian must complete this form for a minor, provide consent for dental treatment and accompany the child during each dental visit. If the parent or guardian consented to treatment in advance, an authorized individual named on Page 1 may bring the child. Treatment will not be provided for unattended children.

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HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle Yes or No. your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Are you under a physician's care now? O Yes O No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain: _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____

Are you taking any medication, pills, or drugs? O Yes O No If yes, please list: _____

Do you take, or have taken, Phen-Fen or Redux? O Yes O No _____

Are you on a special diet? O Yes O No _____

Do you use tobacco? O Yes O No _____

Do you use controlled substances? O Yes O No

Women:

Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

Have you ever been treated with Bisphosphonate drugs such as: Fosamax, Aredia, Zometa, Actonel, Boniva? If so, when did the treatment begin? _____

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Please list any dietary or herbal supplements you are taking, and for what purpose i.e. vitamins, antacids, etc:

_____

_____

Please list any dietary or herbal supplements you are taking and for what purpose: i.e. vitamins, antacids, etc.:

_____

_____

If yes, please answer the following questions to the end of the questionnaire:

Are you taking any of the following medications: (Please circle if YES)

Antacids	Tagamet (cimetidine) or Prilosec (omeprazole)
Dilantin or Tegretol	Serzone (nefazodone)
Barbituates	Diflucan (fluconazole) or Sporonox (itraconazole)
St. John's wort or Kava-Kava	Biaxin (clarithromycin)

Do you use **tobacco**? Yes No If yes, circle type: **smoke** **chew** **vape**
How much **per day**? _____ For how long? _____
Do you want to **quit** using tobacco? Yes No
Do you consume **alcohol**? Yes No
If yes, approximately how many alcoholic beverages **per week**? _____
Do you use any **mood-altering drugs** other than those previously listed? Yes No
If Yes which ones? _____

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): *none* *slight* *moderate* *high*

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permissions to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) Patient Signature Date