Welcome to Country Creek Dental!

We want your experience to be as smooth as possible. Please fill out these documents to help us serve you the best way we can.

Date_____

Patient Name_____ Preferred_____

Street Address_____

City_____ State_____ Zip_____

Cell Phone _____ Home Phone _____

E-mail _____

Social Security #_____-_____-_____

Sex (circle one) Male Female

Marital Status (circle one) Married Single Divorced Widowed

Birth Date: _____/_____/_____

Employer_____

Address(street,city,state,zip)_____

Work Phone _____ext_____

EMERGENCY INFORMATION

Name of relative or friend not living with you_____

Relationship to Patient_____

Phone # with area code (_____)_____

Medical History

Please complete all blanks

Name_____ Date_____

Have you ever had any of the following? (Circle any that apply)

Anemia	Excessive Bleeding	Kidney Disease	Sinus Problems
Arthritis	Fainting	Liver Disease	Stomach Problems
Artificial Joints	Glaucoma	Mental Disorders	Stroke
Blood Thinner	Head Injury	Nervous Disorders	Thyroid Disorder
Bisphosphonate Meds	Heart Disease	Pacemaker	Tuberculosis (TB)
(for Bone Density)	Heart Murmur	Pregnancy	Ulcers
Cancer	Hepatitis, type_____	Radiation Therapy	Venereal Disease
Diabetes	High Blood Pressure	Respiratory Problems	
Epilepsy	HIV	Rheumatism	Other _____

None of above

Are you allergic to (Circle): Penicillin Novocaine Latex Codeine

Other Allergies: _____

Are you being treated for anything at the present time? ____Yes ____No

If yes, please specify_____

List all medications you are taking _____

_____

List any tobacco product you currently use: _____

If female, are you currently Pregnant? ____Yes ____No

Dental Questionnaire

What brings you in today? _____
When was your last professional cleaning? _____
When was your last complete Dental Exam? _____

On a scale from 1 (low) to 10 (high), how do you feel about your smile?

1---2---3---4---5---6---7---8---9---10

If not a 10, what would you change to your smile to increase your satisfaction?

_____

Do you suffer from dental anxiety? ___ Yes ___ No
If Yes, how can we help make your visit less stressful?

_____

Dental History

Please circle any that you have had:

Bonding	Impacted Teeth
Bridge	Implants
Crown or Cap	Jaw Surgery
Deep Cleaning	Orthodontics
Denture	Partial Denture
Extraction	Root Canal
Fillings	TMJ Problems
Gum Surgery	Veneers

Country Creek Dental PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement.**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

_____

_____

_____

INSURANCE INFORMATION

Policy Holders Name: _____

Policy Holders Street Address:_____

Policy Holders City, State, Zip:_____

Policy Holders Phone # w/ Area Code_(___)_____

Patient Relationship to Policy Holder (circle one)
Self/ Spouse / Son / Daughter / Stepchild / _____

Employer Insurance is
through_____

Insurance Company:_____

Group #:_____

Sub. ID # _____Birth date____/____/_____

Social Security #_____

Deductible: $_____ per year. $--Maximum_____

Office Policy for Country Creek Dental PLLC
207 Kings Court, Alcoa, TN
For Handling Insurance

We will do all we can to provide you with the best dental care possible. Any service is based on a friendly, mutual understanding between doctor and patient. We encourage you to ask any question you have. We will try our best to answer anything and provide treatment that is suitable for you.

When we perform services for you, you are financially responsible to us for those services. Your insurance company has an obligation to you – none to us. You are 100 % responsible for any services we provide to you.

You will be provided an estimate of your out-of-pocket expense for treatment. This is an ***estimate***, calculated with the information that you and your insurance company provide us. If you desire the EXACT out-of-pocket expense for bigger cases, we can submit pre-authorization to your insurance. Doing so will delay the timeline in which we can perform your treatment.

If you sign this, you authorize us to file your insurance for you and provide any and all information your insurance company requests. Your insurance coverage may or may not cover your dental care needs- the provisions of your insurance coverage in no way relieves you of your financial responsibility to us. We urge you to contact your insurance company any time you have a question about your coverage.

Our office is run on an appointment basis. We will try our best to accommodate you on appointment times. When we reserve time for you, we expect you to show up or call with 24 hours notice. Failure to keep your appointment or not giving us 24 hours notice may incur a $75.00 charge. We try to contain our costs and thus provide you with more affordable dental care.

I (patient) agree to pay any and all collection expenses should this account be placed with a collection agency. I (patient) agree to pay a reasonable attorney's fee, plus court costs, in addition to the principle and any interest (1.5% per month).

I have read and understand the above policies.

Patient Name_____

Patient Signature_____
(parent's signature if patient is minor child)

Date_____

Parent or Guardian Information

Mother _____ Cell _____

Mother's Employer _____

Work Phone _____

Father _____ Cell _____

Father's Employer _____

Work Phone _____

Address of Parent or Guardian _____
_____

If in foster care

Case Worker _____

Case Worker's Phone _____

Child's School System (Circle one)

Blount County Maryville City Knox County Other _____