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**PATIENT REGISTRATION**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

PATIENT'S BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ EMAIL \_\_\_\_\_@\_\_\_\_\_.com

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SSN: \_\_\_\_\_

HOME/MAILING ADDRESS: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ OTHER #: \_\_\_\_\_

EMPLOYER NAME/ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ DEPT: \_\_\_\_\_ WORK #: \_\_\_\_\_ EXT: \_\_\_\_\_

ARE YOU ALLOWED TO RECEIVE CALLS AT WORK?  YES  NO EMERGENCIES ONLY

PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ CONTACT #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

THEIR EMPLOYER NAME/ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ DEPT: \_\_\_\_\_ WORK #: \_\_\_\_\_ EXT: \_\_\_\_\_

ARE THEY ALLOWED TO RECEIVE CALLS AT WORK?  YES  NO EMERGENCIES ONLY

***IN CASE OF EMERGENCY***

NEAREST RELATIVE NOT LIVING WITH YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ CONTACT #: \_\_\_\_\_

ALTERNATE CONTACT #:  
\_\_\_\_\_



## **MEDICAL HISTORY**

YOUR MEDICAL HISTORY IS EXTREMELY IMPORTANT, PLEASE READ THROUGH THIS SECTION CAREFULLY AND ANSWER AS COMPLETELY AS POSSIBLE. THANK YOU.

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?  YES  NO

NAME OF PHYSICIAN \_\_\_\_\_ TEL #: \_\_\_\_\_

HAVE YOU EVER HAD HIGH BLOOD PRESSURE?  YES  NO

HAS A PHYSICIAN EVER SAID YOU HAVE/HAD HEART TROUBLE?  YES  NO

DO YOU HAVE MITRAL VALVE PROLAPSE?  YES  NO

HAVE YOU EVER HAD ABNORMAL BLEEDING FOLLOWING AN EXTRACTION OR CUT?  YES  NO

HAVE YOU EVER HAD AN ANESTHETIC (EITHER LOCAL OR GENERAL)?  YES  NO

HAS A PHYSICIAN OR DENTIST EVER SAID YOU HAVE/HAD A TUMOR OR CANCER?  YES  NO

ARE YOU ALLERGIC TO PENICILLIN, NOVOCAINE OR ANY OTHER MEDICINE?  YES  NO

ARE YOU ALLERGIC TO ANYTHING OTHER THAN MEDICINE?  YES  NO

ARE YOU ALLERGIC OR SENSITIVE TO LATEX OR METALS?  YES  NO  
LIST ALLERGIES HERE: \_\_\_\_\_

### **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:**

RHEUMATIC FEVER                      YES  NO                       TUBERCULOSIS                      YES  NO

RHEUMATIC HEART DISEASE                      YES  NO                       KIDNEY TROUBLE                      YES  NO

EPILEPSY OR CONVULSIONS                      YES  NO                       ASTHMA/HAY FEVER                      YES  NO

ANEMIA/LUKEMIA/LOW PLATELETS YES  NO                       SYPHILIS                      YES  NO

LIVER TROUBLE/JAUNDICE                      YES  NO                       GLAUCOMA                      YES  NO

THYROID TROUBLE/GOITER                      YES  NO                       ARTHRITIS                      YES  NO

FAINTING OR DIZZINESS                      YES  NO                       HIV/ AIDS                      YES  NO

STOMACH ULCERS                      YES  NO                       STROKE                      YES  NO

HEART MURMUR                      YES  NO                       HEPATITIS                      YES  NO

PROSTATE TROUBLE                      YES  NO                       ECZEMA/HIVES                      YES  NO

PSYCHIATRIC TREATMENT                      YES  NO                       LUPUS                      YES  NO

MULTIPLE SCLEROSIS                      YES  NO                       PACEMAKER                      YES  NO

**DOCTOR/PATIENT PRIVILEGED INFORMATION  
CONFIDENTIAL**

LOW BLOOD PRESSURE YES  NO

JOINT REPLACEMENT YES  NO

ARE YOU PREGNANT? YES  NO

DIABETES YES  NO

HOW LONG \_\_\_\_\_ YEARS

**ARE YOU NOW TAKING ANY OF THE FOLLOWING?**

DRUGS FOR HIGH BLOOD PRESSURE YES NO LIST: \_\_\_\_\_

DRUGS FOR SLEEP YES NO LIST: \_\_\_\_\_

CORTISONE, STEROIDS OR ACTH YES NO LIST: \_\_\_\_\_

ANTICOAGULANTS OR BLOOD THINNERS YES NO LIST: \_\_\_\_\_

TRANQUILIZERS OR SEDATIVES YES NO LIST: \_\_\_\_\_

ANTIBIOTICS YES NO LIST: \_\_\_\_\_

INSULIN YES NO LIST: \_\_\_\_\_

OTHERS YES NO LIST: \_\_\_\_\_

LIST ANY ADDITIONAL MEDICINE YOU ARE TAKING, WHETHER PRESCRIBED OR OVER THE COUNTER:

\_\_\_\_\_

HAVE YOU EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ANY MAJOR ILLNESS OR INJURY OTHER THAN THOSE

NOTED ABOVE? IF SO, LIST: \_\_\_\_\_

PLEASE SIGN AND DATE:

\_\_\_\_\_

\*\*\*\*\*OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY THE OSHA, THE CDC AND THE ADA. ALL INFORMATION ON THESE FORMS IS PROTECTED BY THE DOCTOR/PATIENT PRIVILEGE AND WILL NEVER BE DISCLOSED TO UNAUTHORIZED PERSONS AND/OR ENTITIES. \*\*\*\*\*

## NEW PATIENT POLICY

We welcome you as a new patient and value your preference; therefore, we have established policies that assist us in providing you with quality care in a timely manner. Tennessee State law states that x-rays are the property of the dental practice. However, you are entitled to receive copies of your x-rays. The law requires that you, the Patient, submit a written request to our office before we are allowed to release copies of the x-rays.

**Radiography (X-rays) Policy:** A set of diagnostic x-rays must be taken before being treated by the Dentist or Hygienist. In the event that copies of x-rays are necessary, a copying fee may be charged. Please allow 24-48 hours for fulfillment of your request. We will forward the x-rays to the dental office of your choosing via First-Class Mail or you can schedule a pick-up. Expedited shipping is available, but this must be coordinated with the Office Manager.

**Records Copy Policy:** There is a charge of \$25.00 for copying your records. We suggest that you speak with your new provider to see if the copies of your records will be of any value to him/her, as most times they are not relevant to the new provider, thus avoiding the \$25.00 charge. If the records are still needed, please allow 24-48 hours for fulfillment of your request.

**Promotional Offers:** Please note that we are offering you a “special rate” in any promotional offer that you use. Should you choose not to continue treatment and wish to take your x-rays, you will be charged our **full** fee for said x-rays.

Your signature below indicates that you have read and fully understand the policies and conditions stated above.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (or guardian if patient is a minor)

\_\_\_\_\_  
Name of person signing, if not Patient

## FINANCIAL POLICY

**Payment Policy:** Payment in full is expected at time of service. Please be sure you understand completely what you will be expected to pay before you begin treatment. We offer the following options for payment: Insurance, VISA, MC, AMEX, Discover, third party financing plans. Please verify with the Financial Administrator the various insurance providers we are in network with.

**Cash Policy:** A 5% discount is offered for payment in full when the services are paid for in cash, check or electronic debit cards (PIN required).

**Insurance Policy:** The patient agrees to notify this practice if any changes occur in his/her medical or dental history. The patient (or guardian) agrees to be responsible for total payment of procedures performed in this office, including any amounts that are not covered by medical/dental insurance or any prepayment program that the patient (or guardian) may have. Please note that the figures we provide are **estimates** based on information received from your insurance carrier. We are not responsible for underpayment/or unpaid amounts on the part of your insurance carrier. If you have any questions or would like to dispute payments made on your behalf, it is your responsibility to discuss this with your insurance carrier. In the event of an underpayment from your insurance carrier, a statement will be mailed to you for the remaining balance. Payment in full is expected within 30 days of the statement date, unless prior arrangements have been made with the Financial Administrator.

**Pre-arranged Financial Agreement:** If a financial arrangement for an outstanding balance has been agreed upon with the Financial Administrator, a written and signed copy will be provided to you and must be present in the file. This will ensure that you have no problems at the time of discharge. In all cases the patient (or guardian) agrees to be, and is hereby, fully responsible for any fees necessary to collect payment, such as but not limited to, attorney fees, or court costs necessary to clear the patient's (or guardian's) account.

Your signature below indicates that you fully understand the policies and conditions outlined above.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_, 20\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (or Guardian, if Patient is a minor)

\_\_\_\_\_  
Name of Guardian (if applicable)

**NO SHOW POLICY**

Due to the value of your time and our schedule, our policy is that when a patient does not show for his/her scheduled *and confirmed* appointment or when he/she does not call to give at least a 24 hour notice to re-schedule or cancel the appointment, a fee will be assessed. When a patient does not provide us with sufficient time on a cancellation, another patient loses the opportunity to have their procedures completed a lot sooner.

I, \_\_\_\_\_ (Patient/Guardian name), understand the above policy and I agree to call the office 24 hours in advance if I am unable to keep my appointment. I am aware that failure to do so will result in my being charged a \$50.00 **Broken Appointment Fee**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**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, which makes me aware of my rights to privacy on any medical records this office may be in possession of for: \_\_\_\_\_ (Patient's Name)

Signature \_\_\_\_\_

Date \_\_\_\_\_

**PATIENT RECORDS DISCLOSURE**

In general, the **HIPAA** (Health Information Portability and Accountability Act) privacy rule, gives individuals the right to request a restriction on uses and disclosures of their **PHI** (Protected Health Information). The individual is also given the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the office, instead of at home.

**I wish to be contacted in the following manner (check all that applies):**

**Home Telephone**

- OK to leave a message with detailed information
- Leave message with call back number ONLY

**Written Communication**

- OK to mail to home address
- OK to mail to work/office
- OK to fax to this number

**Work Telephone**

- OK to leave a message with detailed information
- Leave message with call back number ONLY \_\_\_\_\_
- other \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

\_\_\_\_\_  
Patient Signature Dated

\_\_\_\_\_  
Printed Name Date of Birth

**FOR OFFICE USE ONLY**

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

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other-please specify:

\_\_\_\_\_