PARKWAY DENTAL

323 Fox Rd
Knoxville, TN 37922
Phone: (865) 690-5231 Fax: (865) 691-4291

Please take a few minutes to answer the following questions. Doing so will allow us to better assist you with your dental needs.

PATIENT INFORMATION

Date:____________________ Soc. Sec. #_______________________________ Birthdate:______________________

Name: ____ Home Phone: _________________________
Last Name First Name Initial

Address:____ Cell Phone:____________________________

City:__________________________________ State:____ Zip:_____________ E-mail:___________________________

Sex: ☐M ☐F ☐ Minor ☐Single ☐ Married ☐Long Term Partner ☐Divorced ☐Widowed ☐ Separated

Employer: ____ Business Phone: ______________________

Business Address:____ Occupation:__________________________

Referred by:____

In case of emergency, please contact: ____________________________________ Phone: _______________________

LEAVE BLANK IF NO CHANGES PRIMARY INSURANCE

Person Responsible for Account: ____
Last Name First Name Initial

Relationship to Patient: ______________________ Birthdate: ________________ Soc. Sec. #: _____________________

Address: ____ Home Phone: _________________________

City: ____ State: _________________________ Zip: _______________

Responsible Party Employed By: _______________________________________ Business Phone: __________________

Business Address: ____ Occupation: _____________________

Insurance Company: ____

Insurance Company Address: ____

Subscriber ID: ____ Group #: _______________________________

LEAVE BLANK IF NO CHANGES ADDITIONAL INSURANCE

Insured Name: ____
Last Name First Name Initial

Relationship to Patient: ______________________ Birthdate: ________________ Soc. Sec. #: _____________________

Address: ____ Home Phone: _________________________

City: ____ State: _________________________ Zip: _______________

Business Address: ____ Occupation: _____________________

Insurance Company and Address: ____

Subscriber ID: ____ Group #: _______________________________

TURN PAGE OVER TO CONTINUE

DENTAL HISTORY

Former Dentist: ________________________________ Date of Last X-Rays: _________________________________

City, ST: _______________________________________ How Often Do You Floss? _____________________________

Date of Last Dental Visit: _________________________ How Often Do You Brush? ___________________________

Please check all that apply:

Bad Breath............ ☐	Loose Teeth or Broken Fillings......... ☐	Sensitivity to Sweets............ ☐
Bleeding Gums............ ☐	Orthodontic Treatment............ ☐	Sensitivity When Biting............ ☐
Blisters on Lips/Mouth............ ☐	Pain Around Ear............ ☐	Frequent Headaches............ ☐
Fingernail Biting............ ☐	Periodontal Treatment............ ☐	Jaw, Head or Neck Injuries............ ☐
Grinding Teeth............ ☐	Sensitivity to Cold............ ☐	Jaw Difficulty: Clicking and/or Pain...... ☐
Lip or Cheek Biting............ ☐	Sensitivity to Heat............ ☐	Tooth Pain............ ☐

MEDICAL HISTORY

Physician's Name: ____ Date of Last Visit: _________________________

	YES	NO
1. Are you currently under medical treatment?..........................	☐	☐
2. Have you ever had any serious illnesses or operations?.........	☐	☐
3. Are you currently taking any medication?..............................	☐	☐
Please describe: _______________________________		
____		
4. Do you smoke?..	☐	☐
5. Do you use alcohol, cocaine, or other drugs?.....................	☐	☐
6. Do you wear contact lenses?..	☐	☐
7. **(WOMEN ONLY)** Are you:		
Pregnant?..	☐	☐
Nursing?	☐	☐
Taking Birth control pills?..	☐	☐

8. Have you had any allergic reaction to the following:	YES	NO
Local Anesthetics (eg. Novocaine).........................	☐	☐
Penicillin or other Antibiotics................................	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)..................................	☐	☐
Sedatives..	☐	☐
Iodine..	☐	☐
Aspirin..	☐	☐
Other (Please allergies below)	☐	☐

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AIDS............ ☐	Epilepsy............ ☐	Psychiatric Care............ ☐
Anemia............ ☐	Fainting or Dizziness............ ☐	Radiation Treatment............ ☐
Arthritis/Rheumatism............ ☐	Glaucoma............ ☐	Respiratory Disease............ ☐
Artificial Heart Valves............ ☐	Headaches............ ☐	Rheumatic Fever............ ☐
Artificial Joints............ ☐	Heart Murmur............ ☐	Scarlet Fever............ ☐
Asthma............ ☐	Heart Problems............ ☐	Shortness of Breath............ ☐
Back Problems............ ☐	Hepatitis Type_______........ ☐	Sinus Trouble............ ☐
Bleeding Abnormally............ ☐	Herpes............ ☐	Skin Rash............ ☐
Blood Disease............ ☐	High Blood Pressure............ ☐	Stroke............ ☐
Cancer............ ☐	HIV Positive............ ☐	Swelling of Feet/Ankles............ ☐
Chemical Dependency............ ☐	Jaundice............ ☐	Swollen Neck Glands............ ☐
Chemotherapy............ ☐	Jaw Pain............ ☐	Thyroid Problems............ ☐
Chronic Fatigue Syndrome.... ☐	Kidney Disease............ ☐	Tonsillitis............ ☐
Circulatory Problems............ ☐	Latex Sensitivity............ ☐	Tuberculosis .... ☐
Congenital Heart Lesions....... ☐	Liver Disease............ ☐	Tumor/growth on head/neck........... ☐
Cortisone Treatments .... ☐	Low Blood Pressure............ ☐	Ulcer............ ☐
Cough-persistent or bloody.. ☐	Mitral Valve Prolapse......... ☐	Ulcer............ ☐
Diabetes............ ☐	Nervous Problems............ ☐	Venereal Disease............ ☐
Emphysema............ ☐	Pacemaker............ ☐	Other (Please Specify)............ ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Parkway Dental Office, P.C. 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 on my behalf, or my dependents.

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

Signature of Responsible Party: ____ Date: ____________________________