Jeffrey T. Morris, DDS
324 Tyson Ave., Paris, TN 38242
(731)642-7920

Patient Name_____Male____Female____DOB_____Age_____
Address_____City/State/Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Email_____ Preferred method of communication_____
Social Security Number_____ Current Employer_____
Marital Status_____ Spouse's Name_____
Whom may we thank for your referral?_____
Emergency Contact_____ Phone Number_____

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Responsible Party Name (if other than self)_____Date of Birth_____
Address_____City/State/Zip_____
Home Phone_____ Work Phone _____SSN:_____
Current Employer_____

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DENTAL INSURANCE INFORMATION

Policy Holder Name_____ SSN_____ Date of Birth_____
Employer_____ Insurance Co Name_____

Secondary Insurance

Policy Holder Name_____ SSN_____ Date of Birth_____
Employer_____ Insurance Co Name_____

Office Policies and Authorizations

I understand that payment is due for all services at the time they are rendered unless prior arrangements are made with the business office. Cash, Check, Visa, Mastercard, and CareCredit are accepted forms of payment. I understand that I am responsible for payment for all services rendered on my behalf or my dependents. I understand and accept that a 1.5% MPR finance charge is automatically tabulated if my account is 30 days or older. Should my account become delinquent, I will assume all additional collection costs and legal fees. Office policy requires a 24-hour notice for appointment cancellations. Appointments in this office are valuable to you, the patient, and the service provider. We realize that sometimes events arise that may not allow you to call to cancel your appointment. In that event we will be happy to reschedule your appointment, however after 3 missed appointments our office reserves the right not to reschedule further visits. I authorize this office to submit claims for payment for services rendered or necessary pre-authorizations to my insurance company on my behalf and in my name listed as "Signature on File". I further authorize payment of any benefits to office when a claim is filed. I understand that insurance will be estimated and co-payments will be due at time of service. I understand I am responsible for payment regardless of the coverage provided. I authorize release to staff, hospitals, health care service plans, insurance companies, self-insurers, or their representatives, any and all information, records, and radiographs about my medical history, services rendered, and necessary treatment. I authorize this office and staff to take necessary radiographs, study models, photos, and other diagnostic aids as needed to make a full diagnosis. I further authorize this office to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics, sedatives, and other medication (as needed) am fully aware that using anesthetic agents involves certain risks. I authorize this office and staff to use the Universal Precautions as outlined by OSHA and permit the confidential discussion of my medical history. I consent to HIV and Hepatitis blood testing and documentation for needle sticks and injuries resulting during my care.

I, THE UNDERSIGNED, HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE.

Patient or Guardian Signature_____Date_____

MEDICAL HISTORY

PATIENT NAME _____

Birth Date _____

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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

_____

_____

2. Have you ever been hospitalized or had a major operation? Yes No
   If yes, please explain: _____
3. Have you ever had a serious head or neck injury? Yes No
   If yes, please explain: _____
4. Are you taking any medications, pills, or drugs? Yes No
   If yes, please explain: _____
5. Do you take, or have you taken, Phen-Fen or Redux? Yes No
6. Are you on a special diet? Yes No
7. Do you use tobacco? Yes No
8. Do you use controlled substances? Yes No

9. Do you require **Antibiotic Pre-medication** prior to dental work? Yes No
   If yes, please explain the condition:

_____

_____

Women:

10. Are you Pregnant/Trying to get pregnant? Yes No
11. Taking oral contraceptives? Yes No
12. Nursing? Yes No

13. Are you allergic to any of the following?
    Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
    Other _____

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

AIDS/HIV Positive	Yes,	No	Hay Fever	Yes	No
Alzheimer's/Dementia Disease	Yes	No	Heart Attack/Failure	Yes	No
Anaphylaxis	Yes	No	Heart Murmur	Yes	No
Anemia	Yes	No	Heart Pace Maker	Yes	No
Arthritis/Gout	Yes	No	Heart Trouble/Disease	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis (A, B, C)	Yes	No
Artificial Joint	Yes	No	Hives or Rash	Yes	No
Asthma/COPD	Yes	No	Hypoglycemia	Yes	No
Blood Disease	Yes	No	Irregular Heartbeat	Yes	No
Blood Transfusion	Yes	No	Kidney Problems	Yes	No
BP- (High, Low)	Yes	No	Liver Disease/Jaundice	Yes	No
Cancer	Yes	No	Low Blood Pressure	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Chest Pains	Yes	No	Mitral Valve Prolapse	Yes	No
Cold Sores/Fever Blisters	Yes	No	Pain in Jaw Joints	Yes	No
Congenital Heart Disorder	Yes	No	Parathyroid Disease	Yes	No
Convulsions	Yes	No	Psychiatric Care	Yes	No
Cortisone Medicine	Yes	No	Radiation Treatments	Yes	No
Diabetes	Yes	No	Renal Dialysis	Yes	No
Digestive Disorders	Yes	No	Rheumatic Fever	Yes	No
Drug Addiction	Yes	No	Rheumatism	Yes	No
Epilepsy/Seizures	Yes	No	Shingles	Yes	No
Excessive Bleeding	Yes	No	Sinus Trouble	Yes	No
Excessive Thirst	Yes	No	Spina Bifida	Yes	No
Fainting Spells/Dizziness	Yes	No	Stomach/Intestinal Disease	Yes	No
Frequent Cough	Yes	No	Stroke	Yes	No
Frequent Headaches	Yes	No	Tonsillitis	Yes	No
Glaucoma	Yes	No	Thyroid Disease	Yes	No
			Tuberculosis	Yes	No
			Ulcers	Yes	No

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

If yes, please explain: _____

_____

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 _____

DATE _____

Patient Acknowledgement of Privacy Practices

I acknowledge I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g.: my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name _____

Relationship to Patient (if not self) _____

Signature _____

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EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

Situation	Responses	Score
Sitting and Reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching Television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for an hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
TOTAL SCORE		