

D. WAYNE HUGHART, DDS, MS

PRACTICE LIMITED TO ENDODONTICS

109 FOX ROAD
KNOXVILLE, TN 37922

PHONE: (865) 692-2380
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PERSONAL INFORMATION:

NAME: _____
NICKNAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ SEX: _____
BIRTHDATE: _____ SOCIAL SECURITY #: _____
OCCUPATION: _____ EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
EMERGENCY CONTACT: _____ EMERGENCY CONTACT PHONE: _____

DENTAL INSURANCE INFORMATION:

POLICY HOLDER'S NAME: _____ RELATIONSHIP: _____
BIRTHDATE: _____ SOCIAL SECURITY #: _____
EMPLOYER: _____ WORK PHONE: _____
INSURANCE COMPANY: _____ GROUP #: _____

ADDITIONAL DENTAL INSURANCE:

POLICY HOLDER'S NAME: _____ RELATIONSHIP: _____
BIRTHDATE: _____ SOCIAL SECURITY #: _____
EMPLOYER: _____ WORK PHONE: _____
INSURANCE COMPANY: _____ GROUP #: _____

MEDICAL HISTORY:

PLEASE CHECK ALL THAT APPLY:

- | | | |
|--|--|---|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> BLOOD DISEASE |
| <input type="checkbox"/> HEPATITIS OR JAUNDICE | <input type="checkbox"/> PROLONGED BLEEDING | <input type="checkbox"/> HEART TROUBLE/SURGERY |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> FAINTING TENDENCY | <input type="checkbox"/> CANCER OR TUMOR |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> STROKE | <input type="checkbox"/> KIDNEY/BLADDER TROUBLE |
| <input type="checkbox"/> RADIATION TREATMENT | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> ASTHMA OR HAYFEVER | <input type="checkbox"/> PSYCHIATRIC PROBLEM _____ |
| <input type="checkbox"/> COLD SORES | <input type="checkbox"/> TMJ/CLICKING JOINT | <input type="checkbox"/> PROSTHETIC JOINT REPLACEMENT |
| <input type="checkbox"/> HIV OR AIDS | | WHEN? _____ |

SOME MEDICAL CONDITIONS REQUIRE MEDICATION PRIOR TO TREATMENT. IT MAY BE NECESSARY TO RESCHEDULE YOUR APPOINTMENT TO ENSURE YOUR SAFETY.

DO YOU HAVE AN ALLERGY OR INTOLERANCE TO ANY OF THE FOLLOWING?

- PENICILLIN CODEINE SULFA
 ASPIRIN LATEX OTHER _____ PLEASE TURN OVER ➡

PATIENT INFORMATION:

CONTINUED:

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

- CORTISONE DRUGS OR STEROIDS DIET PILLS OR SUPPLEMENTS CHAMOMILE
- ANTICOAGULANTS GINGER COLEUS FORSKOHLII
- BLOOD THINNERS GARLIC FEVER FEW
- TRANQUILIZERS GINKO FISH OIL
- SEDATIVES KAVA-KAVA GAG
- BIRTH CONTROL PILLS HORSE CHESTNUT SEED CPC'S
- BIRTH CONTROL SHOTS BUTCHER'S BROOM PHOSPHATIDYLSERINE
- BIRTH CONTROL IMPLANTS VITAMIN K REISHI
- HORMONE THERAPY BROMELAIN RED CLOVER
- BISPHOSPHONATES WHITE WILLOW

ANY OTHER MEDICATIONS NOT LISTED?: _____

HAVE YOU EVER HAD AN EPINEPHRINE REACTION DURING DENTAL TREATMENT? YES NO

ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS? _____ ARE YOU BREASTFEEDING? _____

WHO IS YOUR GENERAL DENTIST? _____ PHONE #: _____

FINANCIAL ARRANGEMENTS:

ESTIMATED FEES FOR PRIMARY SERVICES ARE LISTED BELOW.
ADDITIONAL CHARGES MAY APPLY.

- EXAMINATION: ..\$100.00 PULP TEST: \$30.00
- ANTERIOR: \$830.00 RETREAT ANTERIOR: \$1100.00
- BICUSPID: \$930.00 RETREAT BICUSPID: \$1200.00
- MOLAR: \$1110.00 RETREAT MOLAR: \$1390.00

FOR YOUR CONVENIENCE WE OFFER THE FOLLOWING METHODS OF PAYMENT. PLEASE CHECK THE OPTION YOU PREFER

- CASH CHECK CREDIT CARD CARE CREDIT HEALTHCARE FINANCING

WE FILE ALL INSURANCE.

FEES ARE DUE WHEN SERVICES ARE RENDERED.

I AUTHORIZE MY INSURANCE COMPANY TO PAY THE DENTIST ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE FOR SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE FOR SAID TREATMENT.

IN ACCORDANCE WITH THE TERMS OF THE CONTRACT, IF THE ACCOUNT IS NOT PAID WITHIN 60 DAYS AFTER THE SERVICES ARE RENDERED, THE ACCOUNT SHALL BE SUBJECT TO A SERVICE CHARGE OF 1 1/2% PER MONTH WHICH SHALL BE COMPOUNDED.

IN THE EVENT THAT THE ACCOUNT, INCLUDING ANY SERVICE CHARGE IS PLACED IN THE HANDS OF A COLLECTION AGENCY OR ATTORNEY, THE PATIENT/GUARANTOR AGREES TO PAY AN ADDITIONAL 50% OF THE BALANCE DUE TOWARDS COLLECTION COSTS, INCLUDING ATTORNEY'S FEE AND COURT COSTS.

I AUTHORIZE THE DENTIST TO UTILIZE MY X-RAYS AND CASE HISTORY FOR PROFESSIONAL PRESENTATIONS, ARTICLES, OR CLINICS.

I HAVE READ AND AGREE TO THE FOREGOING CONDITIONS, AND, TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE CORRECT.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

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