PATIENT REGISTRATION

First Name	ID:	Chart ID:					
Particut Is Policy Holder Responsible Parry Freferred Name	First Name:		Last Name:			1	Middle Initial:
First Name	Patient Is: Policy He	older Responsible Party	Preferred Name:				nema-21
First Name	Responsible Party (if someone other than the patient) —			Commission States of Library Services		
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Responsible Party is also a Policy Holder for Patient	Birth Date:	Soc Sec:				Min.	
Patient Information	[Parancible Demokratical	7 1 1 1 0 p				S LAC.	
Address	Responsible Party is al	so a Policy Holder for Patient	Primary Insurance Poli	cy Holder		econdary Insurance Po	olicy Holder
City: State / Zip: Exs: Cellular	Patient Information						
Home Phone: Work Phone: Ex: Cellular: Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Birth Date: Age: Soc Sec: Drivers Lie: E-mail: Would like to receive correspondences via e-mail. Section 2 Section 3 Employment Full Time Part Time Retired Last Dental Visit Status: Full Time Part Time Retired Last FMX/Pano Student Status: Full Time Part Time Retired Last FMX/Pano Medicaid ID: Pref. Pharmacy: Last FMX/Pano Employer ID: Pref. Pharmacy: Last FMX/Pano Employer ID: Pref. Hyg: Last FMX/Pano Primary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Employer: Ins. Company: Address: Address 2: Address 2: City, State, Zip: City, State, Zip: Rem. Benefits: Rem. Deduct: Secondary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Employer: Ins. Company: Address: Address: Address Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Employer: Rem. Deduct: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other Insured Soc. Sec: Secondary Insurance Secondary Insurance Secondary Insurance Secondary Insurance Secondary Insurance Secondary	Address:		Address 2:				
Sec: Male Female Marital Status: Married Single Divorced Separated Widowed	City:		State / Zip:			Pager	D
Birth Date:	Home Phone:	Work Phone:			Ext:	Cellular	**
E-mail: would like to receive correspondences via e-mail. Section 2	Sex: Male	Female	Marital Status: Marr	ied Single	Divorced	Separated V	√idowed
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Status: Full Time	***************************************			•••••••••••••••••••••••••••••••••••••••		- Section 3	***************************************
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Patient Name:

Andrew R. Lunn, D.D.S. Eaglesoft Medical History

Birth Date:

Date Created:

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, or Are you under a physician's care now? Oyes ONo If yes Have you ever been hospitalized or had a major operation? OYes ONo If yes Have you ever had a serious head or neck injury? OYes ONo If yes Are you taking any medications, pills, or drugs? OYes ONo If yes Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If yes Have you ever taken Fosamax, Boniva, Actonel or any other OYes ONo If yes medications containing bisphosphonates? Are you on a special diet? OYes ONo Do you use tobacco? OYes ONo Do you use controlled substances? O Yes ONo If yes Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Are you allergic to any of the following? Aspirin Penicilin Codeine Acrylic Metal ☐ Latex Sulfa Drugs Local Anesthetics Other? Do you have, or have you had, any of the following? AIDS/HIV Positive OYes ONo Contisone Medicine OYes ONO Hemophilia OYes ONo Radiation Treatments OYes ONo Alzheimer's Disease OYes ONo Diabetes OYes ONo Hepatitis A OYes ONo Recent Weight Loss OYes ONo Anaphylaxis OYes ONo Drug Addiction OYes ONo Hepatitis B or C OYES ONO Renal Dialysis OYes ONo Anemia OYes ONo Easily Winded OYes ONo Herpes OYes ONo Rheumatic Fever OYes ONo Angina OYes ONo Emphysema OYes ONo High Blood Pressure OYes ONo Rheumatism OYes ONo Arthritis/Gout Oyes ONo Epilepsy or Seizures OYes ONo High Cholesterol O Yes O No OYes ONo Scarlet Fever Artificial Heart Valve OYes ONo Excessive Bleeding OYes ONo Hives or Rash OYes ONo Shingles OYes ONo Artificial Joint Oyes ONo Excessive Thirst OYes ONo Hypoglycemia OYes ONo Sickle Cell Disease OYES OND Asthma OYes ONo ainting Spells/Dizziness OYes ONo Irregular Heartheat OYes ONo Sinus Trouble OYes ONo Blood Disease OYes ONo Frequent Cough OYes ONo Kidney Problems OYes ONo Spina Bifida OYes ONo Blood Transfusion OYes ONo Frequent Diarrhea OYes ONo Leukemia OYes ONo Stomach/Intestinal Disease OYES ONO Breathing Problems OYes ONo Frequent Headaches OYes ONo Liver Disease OYes ONo Stroke OYES OND Bruise Easily OYes ONo Genital Herpes OYes ONo Low Blood Pressure OYes ONo Swelling of Limbs OYes ONo Cancer OYes ONo Glaucoma OYes ONo Lung Disease OYes ONo Thyroid Disease OYes ONo Chemotherapy O'Yes ONo Hay Fever OYes ONo Mitral Valve Prolapse OYes ONo Tonslitis OYES ONO O Yes ONo Heart Attack/Failure OYes ONo Osteoporosis OYes ONo Tuberculosis OYES ONO Cold Sores/Fever Blisters OYes ONo Heart Murmur OYes ONo Pain in Jaw Joints OYes ONo Tumors or Growths OYES OND Congenital Heart Disorder OYes ONo Heart Pacemaker OYes ONo Parathyroid Disease OYes ONo Ulcers OYes ONo Convulsions OYes ONo Heart Trouble/Disease OYes ONo Psychiatric Care OYes ONo Venereal Disease Oyes ONo Yellow Jaundice OYes ONo Have you ever had any serious liness not listed above? O Yes ONo If yes 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. Sonature of Patient, Parent or Guardian: X Date:



ANDREW R. LUNN, D.D.S.

1606 GUNBARREL ROAD, SUITE 104' PH: (423)553-8858' FAX: (423)553-8865' WWW.CHATTANOOGADENTIST.COM

Payment, Insurance, and Authorization Agreement

I agree to be fully responsible for total payment to Andrew R. Lunn, D.D.S. for procedures performed in the office or at another facility while under his care.

I understand my insurance is a contract between me and the insurance carrier, not between the insurance carrier and Andrew R. Lunn, D.D.S., and that I am still responsible for all dental fees processed from this office. At the time services are rendered, I understand I am responsible for my insurance deductible, co-pay, and/or any amount not covered by my insurance plan. If my insurance company has not paid their portion within 45 (forty-five) days, I understand that the balance will become due and payable by me. If for any reason the account is not paid in a timely manner, I understand the account will be turned over for collections and that I am responsible for all collection cost.

If I do not have dental coverage, I understand I am responsible for the entire amount at the time of service unless other arrangements have been made between me and our billing department. If I do have dental insurance, I assign and direct the insurance company to make immediate payment to Andrew R. Lunn, D.D.S. I agree for Andrew R. Lunn, D.D.S. to release any information acquired in the course of examination or treatment.

If the patient is under the age of eighteen (18) years old, the parent, legal guardian, or personal representative bringing the patient for treatment and by their signature below, is responsible for the total payment for treatment rendered by Andrew R. Lunn, D.D.S. If this consent is signed by a parent, personal representative or legal guardian on behalf of the patient, please indicate the relationship below:

Personal Guardian or Representative's Name:					
Relationship to Patient:					
Signature:	Date:				



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Cancellation/ No-show Policy

- We will make every effort to fulfill your scheduling requests.
- Please make every effort to meet your scheduled therapy appointments, as the opportunity to reschedule your appointments is limited to emergencies only.
- Non-emergency requests for changes will be made on a space available basis only with no guarantee of preferred days/ times.
- IF you must cancel your appointment, we require a 24-hour notice.
- One cancellation without a 24-hour notice (or a "no show") may lead to a change in your preferred schedule.

I have read and understand Chattanooga Family Dentistry's Cancellation/ No-show policy and agree to the terms.

Signature	Date	



ANDREW R. LUNN, D.D.S	A	1	1	D	R	E	V	V	R.	L		1	VI	V.	\Box	D	S		
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1606 GUNBARREL ROAD, SUITE 104' PH: (423)553-8858' FAX: (423)553-8865' WWW.CHATTANOOGADENTIST.COM

signing this Consent Form I am gi	have had full opportunity to read and consider and you're Notice of Privacy Practices. I understand that by twing my consent to your use and disclosure of my protected atment, payment activities and health care operations.
	Date:
If this consent is signed by a perso following:	onal representative on behalf of the patient, complete the
Personal Representative's Name:	
Relationship to Patient:	
Co	nsent for Photography
I give my consent for Andrew R. I structures for the purposes of diagrammatical research.	Lunn, D.D.S. to photograph any tissue, bone, or anatomical nosis, treatment, patient education, presentation, or
Signature:	