



# Ridgeview Family Dental

[www.ridgeviewfd.com](http://www.ridgeviewfd.com)

222 Headtown Rd. Jonesborough, TN 37659

info@ridgeviewfd.com

423.753.9191

## Medical History

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

Last

First

MI

Please circle any of the following that apply to you.

- |                      |                       |                     |                         |
|----------------------|-----------------------|---------------------|-------------------------|
| -ADD                 | -ADHD                 | -AIDS/HIV           | -Acid Reflux            |
| -Alcohol/Drug Addict | -Allergies            | -Allergy to Metal   | -Angina                 |
| -Artificial Joints   | -Anxiety              | -Anemia             | -Artificial Heart Valve |
| -Cancer              | -Asthma/Emphysema     | -Arthritis          | -COPD                   |
| -Defibrillator       | -Birth Control        | -Autism             | -Cold Sores             |
| -Excessive Bleeding  | -Depression           | -Blood Thinner      | -Dialysis               |
| -Glaucoma            | -Dry Mouth            | -Chemo              | -Epilepsy/Seizure Dis   |
| -Heart Surgery       | -Head Injuries        | -Diabetes           | -Heart Murmur           |
| -High Blood Pressure | -Heart Trouble        | -Gastric Bypass     | -Herpes                 |
| -Jaundice            | -High Cholesterol     | -Hearing Aids       | -Impaired Memory        |
| -Liver Disease       | -Kidney Disease       | -Hepatitis A, B, C  | -Lichen Planus          |
| -Migraines           | -Lung Disease         | -Hip Replacement    | -PVC                    |
| -Pacemaker           | -Neck Injury          | -Kidney Problems    | -Premedicate            |
| -Radiation Treatment | -Periodontal Disease  | -Mental Disorders   | -Rheumatic Fever        |
| -Rheumatism          | -Respiratory Problems | -Nervous Disorders  | -Sinus Problems         |
| -Skin Cancer         | -STD's                | -Pregnancy          | -Thyroid Disease        |
| -Stress              | -Sleep Apnea          | -Restless Leg Synd  | -Ulcers                 |
| -Tobacco User        | -Stroke               | -Steroid Medication |                         |
| -Osteoporosis        | -Tuberculosis         | -Syncope            |                         |

Has there been any medical treatment, including surgery, in the last year? If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

Please list below any medications you are currently taking.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies. \_\_\_\_\_

Do you have any medical conditions not listed on this form? \_\_\_\_\_

Do you snore or use a CPAP? If yes, please specify. \_\_\_\_\_

Signature \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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### **Patient Communications (HIPAA)**

By Law, without your authorization, Ridgeview Family Dental cannot communicate with:

1. Your Spouse
2. Your adult children or caregivers
3. Your parents (if you are age 18 or over)

Ridgeview Family Dental may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial information

**SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS** Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD). Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

**Please indicate below the name of people who we may communicate with regarding your appointment, medical/dental or account information.**

My Spouse \_\_\_\_\_

My Adult Children \_\_\_\_\_

My Parents \_\_\_\_\_

My Caregiver \_\_\_\_\_

Other \_\_\_\_\_

I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member or guardian. \_\_\_\_\_

**Patient Name Printed:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Ridgeview Family Dental**  
222 Headtown Road  
Jonesborough, TN 37659  
Office: 423.753.9191 Fax: 423.753.9644  
[www.ridgeviewfd.com](http://www.ridgeviewfd.com)

## **Financial Policy**

We are committed to providing you with the best possible dental care. In order to provide that care, all estimated co-payments are due at the time services are rendered. If you have any questions concerning our fees and methods of payment, please do not hesitate to ask. In order to have a definite understanding regarding dental fees, we have listed our Financial Policies for you below:

**Dental Insurance-** *Our office staff understands dental insurance and will be glad to assist you in obtaining the maximum benefits specified in your contract.*

- A.) Your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
- B.) Our fees generally, but not necessarily, fall within the usual and customary fee structure, determined by your insurance carrier. The fee schedule that your dental insurance considers "usual and customary" is 18-24 months old. They pay fees in the lower 40-80 percentile of any fees submitted.
- C.) Not all dental services are covered benefits in all contracts.
- D.) You (not the insurance company) are responsible for payment of all fees for services rendered to you.
- E.) For patients who have insurance, we reserve the right to request full payment of the estimated benefit that the insurance MIGHT be expected to pay, and any co-payment at the time care is initiated.
- F.) As a courtesy when accepting direct assignment from the insurance company, we require 100% of your portion and deductible to be paid at the time services are rendered.

### **OTHER METHODS OF PAYMENT**

- A.) We accept check, cash or credit cards (Master Card, Visa, Discover and AmEx) for payment.
  - B.) Care Credit- 12 months zero interest finance plan. Credit approval required.
- \*Returned check policy: A \$35.00 charge will be applied to the account for each returned check.

Pre-Treatment Estimates (PTE) are provided to help you understand and prepare for your payment prior to treatment. These are only an estimate of insurance payments at the time of presentation. Insurance policies are subject to change. Treatment estimates are only valid for 4 months from presentation. I understand that all fees are the patient's sole responsibility regardless of insurance availability. In the event collection procedures are necessary, the patient/guardian will be held accountable for all collection costs (example: attorney fees, court costs, collection agency fees. Etc.)

I understand and agree with the financial policy of the office.

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Signature

Date

**Ridgeview Family Dental  
222 Headtown Road  
Jonesborough, TN 37659  
423.753.9191**

**RECORD RELEASE AUTHORIZATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I authorize \_\_\_\_\_  
(name of previous office) (phone number)

\_\_\_\_\_  
(street address) (city, state, zip)

to release to Ridgeview Family Dental, Drs. Wes Lauderback and Trey Lunsford at 222 Headtown Road, Jonesborough, TN 37659.

The reason for the release of these records is:

\_\_\_\_\_ New Insurance                      \_\_\_\_\_ Legal Reasons

\_\_\_\_\_ Moving                                      \_\_\_\_\_ Dissatisfied with care

Other, please list reason \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or legal guardian                                      Date

# **Ridgeview Family Dental**

**Dr. Wes Lauderback and Dr. Trey Lunsford**

## **24 Hour Notice**

**Our cancellation policy states that if an appointment is cancelled without 24 hours' notice, a \$50.00 fee will be assessed. For more than 3 missed or no-show appointments, the patient relationship with the office will be terminated.**

**Your health is our first concern, and we believe it to be in your best interest to commit to the appointments you make in our office to minimize your dental needs.**

**Thank you in advance for understanding.**

**Sincerely,  
Dr. Wes Lauderback and Dr. Trey Lunsford**

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**Patient Signature**

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**Date**

# Ridgeview Family Dental

**Dr. Wes Lauderback**

**Dr. Trey Lunsford**

## X-RAY CONSENT FORM

Dental x-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Dental x-ray films detect much more than cavities. For example, x-rays may be needed to assess erupting teeth, diagnose bone diseases, detect cysts, tumors, and abscesses, evaluate the results of an injury, plan orthodontic treatment, or diagnose gum disease.

If dental problems are found and treated early, before they become visible or painful, dental care is much more comfortable and affordable. Dental x-rays are a part of a comprehensive oral examination. However, your dental insurance may not cover the fee for x-rays.

Please note that new dental x-rays will be taken. Please understand that they may or may not be covered by your dental insurance. You are responsible for all fees if your insurance company does not pay for the x-rays.

If you have current x-rays from a previous dentist that are within one year, and are diagnostic quality, we can use those, and new x-rays will not be needed. You are responsible for getting those to us. The x-rays need to be received prior to your appointment date. If not, we will be taking new x-rays as part of our comprehensive exam. Protocol for future x-rays will be determined based on individual risk factors. By signing below, you acknowledge this agreement.

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Patient Name

Date