Dr. Sviatoslav Bouz, DDS
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9493 David Smith Lane
Ooltewah, TN 37363

Welcome

Date: _____

Full Name: _____ Preferred Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Cell Phone #: _____ Home Phone #: _____

Preferred Contact Method: ☐ Text ☐ Call ☐ Email ☐ Emergency Contact

Sex: _____ Date of Birth: _____ Social Security #: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Dental Insurance

Primary

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder SSN: _____

Policy Holder Date of Birth: _____

Insurance Card ID: _____

Group Number: _____

Secondary

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder SSN: _____

Policy Holder Date of Birth: _____

Insurance Card ID: _____

Group Number: _____

I UNDERSTAND THAT THE PORTION OF MY TREATMENT NOT COVERED BY INSURANCE IS DUE AND PAYABLE AT EACH VISIT. IF MY INSURANCE COMPANY HAS NOT PAID THEIR PORTION WITHIN 60 DAYS OF BEING PROPERLY BILLED, I UNDERSTAND THAT THE BALANCE WILL BECOME DUE AND PAYABLE BY ME.

A MISSED APPOINTMENT IS A LOSS TO EVERYONE. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS GIVEN LESS THAN A 24-HOUR NOTICE.

I UNDERSTAND THERE WILL BE A $25 SERVICE CHARGE FEE FOR ANY RETURNED CHECK. I ALSO AGREE TO PAY ANY INTEREST, COLLECTION COSTS, AND ATTORNEY FEES INCURRED TO AFFECT COLLECTION ON THIS ACCOUNT.

I UNDERSTAND AND AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, AND/OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR FOR A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS, AND PERFORM ANY TREATMENT THAT MAY BE INDICATED.

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLDEGE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

Signature of Responsible Party: _____ Date: _____

Relationship to Patient: _____

Medical History

Physician Name: _____ Physician Address: _____

Do you need to pre-medicate with antibiotics for dental treatment? Yes ☐ No ☐

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ Other _____

Are you presently taking any medications prescribed by a physician or dentist? Yes ☐ No ☐

If yes, please list: _____

Have you had major surgery? Yes ☐ No ☐ If yes, explain: _____

(Females) Are you taking hormones or birth control? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐

HAVE YOU HAD OR DO YOU NOW HAVE:

	Yes	No		Yes	No
Anemia	☐	☐	Sleep Apnea	☐	☐
Arthritis, Rheumatism	☐	☐	Stomach Ulcers	☐	☐
Asthma	☐	☐	Transplants	☐	☐
Cancer	☐	☐	Allergies, Hay Fever	☐	☐
Chemotherapy	☐	☐	Artificial Heart Valves	☐	☐
Diabetes	☐	☐	Artificial Joints	☐	☐
Headaches	☐	☐	Excessive Bleeding	☐	☐
Jaundice	☐	☐	Blood Disease, Clotting Disorder	☐	☐
Kidney Disease	☐	☐	Chemical Dependency	☐	☐
Radiation Treatments	☐	☐	Circulatory Problems	☐	☐
Sickle Cell Anemia	☐	☐	Cortisone Treatments	☐	☐
Thyroid Problems	☐	☐	Cough, Persistent or Bloody	☐	☐
Autism Spectrum Disorder	☐	☐	Emphysema	☐	☐
Birth Defects	☐	☐	Epilepsy	☐	☐
Bladder Issues	☐	☐	Fainting	☐	☐
Cerebral Palsy	☐	☐	Glaucoma	☐	☐
Congenital Heart Disease	☐	☐	Herpes	☐	☐
Convulsions	☐	☐	High Blood Pressure	☐	☐
Cystic Fibrosis	☐	☐	Any Immune Deficiency	☐	☐
Developmental Delays	☐	☐	Low Blood Pressure	☐	☐
GERD/Acid Reflux	☐	☐	Mitral Valve Prolapse	☐	☐
Genetic/Inherited Conditions	☐	☐	Osteoporosis	☐	☐
Glandular Conditions	☐	☐	Osteopenia	☐	☐
Heart Murmur	☐	☐	Pacemaker	☐	☐
Hemophilia	☐	☐	Respiratory Disease	☐	☐
Hepatitis	☐	☐	Rheumatic Fever	☐	☐
HIV	☐	☐	Scarlet Fever	☐	☐
Hydrocephaly	☐	☐	Shortness of Breath	☐	☐
Impaired Hearing	☐	☐	Sinus Trouble	☐	☐
Impaired Speech	☐	☐	Skin Rash	☐	☐
Impaired Vision	☐	☐	Slow Wound Healing	☐	☐
Loss of Consciousness	☐	☐	Stroke	☐	☐
Mental/Intellectual/Emotional Delay	☐	☐	Swelling of Feet or Ankles	☐	☐
Motor Deficits	☐	☐	Tonsillitis	☐	☐
Mouth Breathing	☐	☐	Tuberculosis	☐	☐
Shunt Placement	☐	☐	Tumor or Growth on Head/Neck	☐	☐
Reactive Airway Disease	☐	☐	Ulcer	☐	☐
Receipt of Blood Products/Transfusions	☐	☐	Venereal Disease	☐	☐
Seizures	☐	☐	Unexplained Weight Loss	☐	☐
Sexually Transmitted Infections	☐	☐	Consumption of Alcoholic Beverages	☐	☐

Have you any disease, condition, or problem not previously listed? _____

Dental History

Date of last dental visit? _____ Date of last dental X-rays? _____

Who was your last dentist? _____ Phone: _____

Are you having any dental problems that require immediate attention? _____

_____

How often do you floss per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3

How often do you brush per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3

Have you ever had an allergic reaction to local or general anesthetics? ☐ Yes ☐ No

If yes, please explain: _____

How do you feel about the appearance of your smile? _____

_____

Have you ever had an unpleasant dental experience? If yes, please explain: _____

_____

PLEASE DISCLOSE ANY KNOWN DENTAL HISTORY/CONDITIONS:

	Yes	No		Yes	No
Bad Breath	☐	☐	Cigarette, Pipe, or Cigar Smoking	☐	☐
Clench or Grind Teeth	☐	☐	Smokeless Tobacco	☐	☐
Bleeding Gums	☐	☐	Dry Mouth	☐	☐
Cavities/Decayed Teeth	☐	☐	Food Collection Between Teeth	☐	☐
Excessive Gagging	☐	☐	Growths or Sore Spots in your Mouth	☐	☐
Inherited Dental Characteristics	☐	☐	Gums Swollen, Tender, or Bleeding	☐	☐
Injury to Teeth, Mouth, or Jaw	☐	☐	Head, Neck, Jaw Pain or Aches	☐	☐
Jaw Joint Problems (Popping, etc.)	☐	☐	Lip or Cheek Biting	☐	☐
Mouth Sores or Fever Blisters	☐	☐	Loose Teeth or Broken Fillings	☐	☐
Sucking Habit After One Year of Age	☐	☐	Mouth Breathing	☐	☐
Toothache	☐	☐	Orthodontic Treatment	☐	☐
Blisters on Lips or Mouth	☐	☐	Nitrous Oxide Use	☐	☐
Burning Sensation on Tongue	☐	☐	Periodontal Treatment	☐	☐
Chew on One Side of the Mouth	☐	☐	Sensitivity to Pressure or Irritants (Cold, Heat, Sweets, etc.)	☐	☐

Do you have any other dental conditions? _____

ALL TREATMENT IS BY APPOINTMENT. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS.