

Dr. Michael Edenfield

Office: 865-686-0050 Fax: 865-686-0053
2937 Essary Rd Knoxville Tennessee 37918
E-mail: dredenfield@bellsouth.net

PLEASE COMPLETE ALL QUESTIONS

Personal Demographics

Patient Name: _____

Birth Date: _____ SSN: _____ Sex: Male/Female

Address of Home: _____

City: _____ State: TN Zip: _____

Home Phone#: (_____) _____ Work Phone#: _____ Cell Phone#: _____

ISC Information

Name of ISC: _____ ISP End Date: _____

ISC Agency: _____

ISC Office#: (_____) _____ ISC Pager: _____ ISC Fax: _____

ISC E-mail Address: _____

Is this Patient under the Self Determination Waiver? YES NO

Emergency Contact: _____ Phone#: _____ Relationship to Patient: _____

Person Responsible for Scheduling Appointment: _____ Phone#: _____

Pharmacy Number: _____ **All prescriptions** will be called into this pharmacy.

If pharmacy changes, please contact our office.

Who or What Agency will be Responsible for Bringing the Patient to the Appointment?

Name/Agency: _____ Number: (_____) _____

How will services be funded? Please Circle One:

State of TN/Waiver Michael Dunn Center Open Arms Other

Personal History

What is the reason for this visit? _____

Is the patient in pain now? YES NO Date of last dental visit: _____

Are previous dental exam records available? YES NO

If yes, will you fax the records to our office to help us create a treatment plan? YES NO

Does dental treatment make the patient nervous? YES NO UNKNOWN

If yes, what are the apprehensions or phobias? (i.e. dentists, needles, dental chair) _____

Health History

Do you now have, or have you had, any of the following conditions or diseases? If so please include the year it occurred.

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Radiation	<input type="checkbox"/> Cancer	<input type="checkbox"/> Pregnant now
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Smoke
<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Use Fen-Phen
<input type="checkbox"/> Sensitive to Metals	<input type="checkbox"/> Seizure Disorder		
<input type="checkbox"/> Received Antibiotic Prior to Dental Treatment in the Past			
<input type="checkbox"/> Other (please specify) _____			

Is the patient allergic to any medications? YES NO

If yes, please list: _____

Is the patient currently taking any medications? YES NO

If yes, please list: _____

To the best of my knowledge, all preceding answers are true and correct. I also agree to notify the office immediately of any changes in the above information.

I hereby apply for treatment by the above dentist, their associates and/or assistants. Treatment may include X-rays, injections and/or such office procedures deemed necessary, and, I accept the risks and complications associated with such procedures.

I authorize the release and use of dental records gathered by this office as they deem necessary, including study models, photographs, and radiographs. I also authorize the release of information necessary for filing and insurance; and direct payments to the office for any amounts due on my claim under the stated policies or any other policy I may be asked to be filed. I have been given a notice of the privacy practices for this office and agree to all information contained within.

I understand that a parent, adult guardian, or caregiver must accompany any minor child OR special needs person and stay in the office until their dental treatment is completed.

APPOINTMENT POLICY

We respect the importance of your time and work very hard to schedule appointments that accommodate the busy needs of all our patients. In return, we ask that our patients make every effort not to change reserved dental appointments. Broken or missed appointments create scheduling problems for other patients and our dental practice as well.

Signature of Patient: _____ Date: _____

Signature of parent, guardian, or caregiver: _____ Date: _____

Personalized Patient Questionnaire

Communication and trust form the basis of all our relationships and in order for us to understand and know a little more about the individual, we would appreciate any additional information that could assist us in providing the most personal care possible.

Patients Name and Nick-name (if any): _____

Does the patient like any of the following?

- a) Music
- b) Reading or looking at books
- c) Watching television
- d) Sports
- e) Movies
- f) Hobbies

If yes to any of the above, please elaborate on the specifics: _____

Is there something else specific to the individual that would enable us to interact with the person on a more personal level? i.e., some patients are very much like “sticklers: about being on time and often ask about the time, others have a favorite “something” they like to talk about, and others want something very special such as a coke, juice or something special to eat. Please let us know about any unique areas of interest for each patient because this knowledge allows us to better understand them and, in many instances, enables us more easily to establish a trusting staff/patient relationship.

Michael E Edenfield, DDS

Office 865-686-0550

Informed Consent for Oral Surgery and Anesthesia

Patient: _____ Date: _____

Although infrequent, I understand that complications can arise from dental surgery or anesthetic procedures and these complications may include but are not limited to:

- Infection
- Excessive bleeding
- Bruising
- Injury to adjacent teeth or fillings
- Sinus involvement
- Injury to underlying nerves with resultant temporary or permanent loss of motor functions, numbness, tingling, or burning sensations in the lip, tongue, chin or teeth
- Decision to leave small root tips
- Allergic reaction
- Inflammation or soreness at IV site
- Stiffness of jaw muscles and jaw joint (TMJ)
- Fractured jaw
- Possibility of instrument breakage in the canal possibly requiring retreatment, root canal surgery, or extraction

Swelling, discomfort and drowsiness are normal following surgery, root canal therapy, and anesthesia. Prescription drugs may also cause your reflexes to be altered, and it is very important to exercise caution after your treatment. Patients should not be left alone and should be monitored to ensure normal breathing occurs. Effects of the sedation medication generally last for only a few hours before being expelled by normal body functioning. Post operative instructions are given to the patient's guardian or caregiver after all procedures and should be strictly adhered to without exceptions.

I understand that unforeseen conditions or anesthetic emergencies may arise, and I authorize the doctor to use his skill and judgment to rectify said events which may also require additional surgery and/or screening of my blood.

I understand that it is my responsibility to keep the doctor informed of the patient's current medications and notify him in writing if additional medications are being taken since the last dental visit and/or procedure.

By signing, I consent to any and all treatment that the doctor feels are necessary for proper dental care for this and subsequent appointments. It is not the responsibility of our office to notify parent or legal guardian of appointment dates. This agreement remains in effect until our office is notified in writing to withdraw the consent. I am aware that the patient should not have any food or drink five hours prior to each dental appointment. If the patient is diabetic, I should notify the office for instructions.

I have read and understand the possible complications that have been explained to me. I have also been given a copy of this document and encouraged to call the office at 865-686-0050 should I have any questions.

Witness: _____ Signed _____
(Patient/Parent or Guardian)

Date: _____ Signed: _____
(Treating Dentist)

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Directions to Knoxville Clinic

From the West:

.DIRECTIONS*****

From the East:

.DIRECTIONS*****

***Please note that on scheduled clinic days, we may be reached at 865-686-0050. Don't hesitate to call if you have any questions or problems locating the clinic.

Patient Name: _____

Appointment Date: _____

BEFORE YOUR APPOINTMENT:

*Pick up the prescription from the patient's pharmacy to take one hour prior to appointment.

NO FOOD OR WATER FOR 5 HOURS PRIOR TO THE APPOINTMENT (If patient is diabetic, contact our office for instructions).

***Patients should take normal daily medications the day of the appointment unless instructed by our doctor or the patient's PCP to discontinue.

IT IS EXTREMELY IMPORTANT THAT THE PATIENT ARRIVES ON TIME FOR HIS/HER APPOINTMENT SO THAT WE CAN MINIMIZE ANY WAITING TIME FOR OUR PATIENTS. ALSO, IT IS VERY IMPORTANT ALL APPOINTMENTS ARE KEPT WITH THE EXCEPTIONS OF A MEDICAL EMERGENCY.