Brad W. Sundstrom, D.M.D.

7044 Lee Highway, Chattanooga, TN 37421

Phone: (423) 894-0650 Fax: (423) 894-0720 Email: bradwsundstromdmd@hotmail.com

It is our desire to provide you with exceptional dental treatment in a timely, professional manner. Please know that we respect and protect your privacy, however there may be a possibility that we will be contacting other health care professionals (physicians, dental specialists, etc.) and insurance companies. We care about your general health. We are "Excellence by Choice"

Patient Information:

Today's Date: _____

Name: Last:_____First: _____ MI:____ Preferred Name: _____

Social Security Number: _____ DOB:_____ Age: _____ Sex: _____

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Work: (_____)_____ Other: (_____) _____

Email: _____ Employer: _____

Patient is: (Circle One) Child Single Married Separated Divorced Other

How did you hear about our office _____

Primary Dental Insurance Information

Insured Name: _____ DOB: _____ SSN: _____

Relationship to patient: _____ Insured Employer: _____

Insurance Company: _____ Group number: _____ Ins ID Number: _____

Insurance Address: _____ Ins Phone Number: _____

Secondary Dental Insurance (if applicable)

Insured Name: _____ DOB: _____ SSN: _____

Relationship to patient: _____ Insured Employer: _____

Insurance Company: _____ Group number: _____ Ins ID number: _____

Insurance Address: _____ Ins Phone Number: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ Phone: (_____) _____

General Information

Reason for visit: _____ Last dental visit: _____

How do you feel about your smile? Good Fair Poor Have you ever had a bad dental experience? Yes No

Please circle the following that apply to you:

Bad Breath	Bleeding	Broken Fillings	Sores/Growth in mouth	Periodontal problems
Grinding Teeth	Jaw Pain	Loose Teeth	Sensitivity to cold	Sensitivity to hot

Medical Information

Are you currently being treated for any medical conditions? _____ If yes, please list conditions that you are being treated for: _____

Physician's Name and Phone Number: _____

Please list all medications currently taking and dosage: _____

Have you ever had any allergies to any of the following?

Amoxicillin Latex Lortab/Hydrocodone Motrin Penicillin Percocet Tylenol
Other (please explain) _____

Women: Are you or is there any chance that you are pregnant? _____ Are you taking birth control? _____

Are you nursing? _____

Please circle any of the following that you have or have had in the past:

ADD/ADHD	Blood Disease/Transfusion	Glaucoma	Mitral Valve Prolapse	Thyroid Disease
AIDS/HIV	Bruise Easily	Heart Murmur	Nervousness	Tobacco Habit
Anemia	Cancer	Heart Problems	Pacemaker	Tonsillitis
Artificial Heart Valves	Circulatory Problems	Hepatitis	Psychiatric Problems	Tuberculosis
Artificial Joints	Diabetes	High Blood Pressure	Low Blood Pressure	Ulcers
Arthritis/Rheumatism	Epilepsy	Jaw Problems/TMJ	Respiratory Problem	
Asthma	Fainting	Kidney Disease	Sinus Trouble	
Back Problems	Fever Blisters/Ulcers	Liver Disease	Stroke	

I certify that the above information is complete and correct to my knowledge. I agree to be treated by Brad W. Sundstrom. I further understand that payment is due at the time that services are rendered. Any outstanding balance will be subject to attorney fees, court costs, and/or collection fee and will be added to my account.

Patient/Parent Signature: _____ Date: _____

Brad W. Sundstrom, D.M.D.

7044 Lee Highway, Chattanooga, TN 37421

Phone: (423) 894-0650 Fax: (423) 894-0720 Email: bradwsundstromdmd@hotmail.com

AUTHORIZATION FOR DENTAL TREATMENT

I hereby authorize **Dr Brad W. Sundstrom, D.M.D** and his associates to provide dental services, prescribe, dispense and/ or administer drugs, medications, antibiotics and local anesthetics that he or his associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medication, antibiotic or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can involve, but are not limited to:

Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance, or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and his associates and to take medications as directed.

Alternative treatments options, including no treatment have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Date: _____

Print Name (Patient): _____

Patient/Parent or Guardian Signature: _____

7044 Lee Highway, Chattanooga, TN 37421

Phone: (423) 894-0650 Fax: (423) 894-0720 Email: bradwsundstromdmd@hotmail.com

Written Financial Policy

Thank you for choosing Brad W. Sundstrom, D.M.D. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost if optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You may choose from:

- Cash, Check, Visa, Mastercard
- CareCredit- NO INTEREST (if paid within promotional period. Otherwise, interest assessed from purchase date.) Minimum monthly payment required. Subject to credit approval:
    - Allows you to pay up to 12 months with NO INTEREST
    - Convenient, low monthly payment plans also available
    - No annual fees or prepayment

Please note:

The required payment of deductibles and co-insurances must be paid prior to the beginning of your treatment. In the event that a balance is carried with our office, the undersigned agrees that he/she is responsible for **any and all** charges incurred on your account. If the account has to be placed with a collection agency or with an attorney, the undersigned agrees to pay any and all reasonable costs associated with the collection and/or attorney fees.

For patients with dental insurance, we are happy to work with your insurance carrier to maximize your benefits and directly bill them for reimbursement for your treatment.

There will be a $30.00 charge for all returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or may need.

Date: _____

Print Name (Patient): _____

Patient/Parent or Guardian Signature: _____

Brad W. Sundstrom, D.M.D.

7044 Lee Highway, Chattanooga, TN 37421

Phone: (423) 894-0650 Fax: (423) 894-0720 Email: bradwsundstromdmd@hotmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

For the Office of BRAD W SUNDSTROM DMD

I, (print patients name) _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature of Patient or Legal Guardian

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please specify)_____