David M. Kimler Dentistry, PLLC

MEDICAL AND DENTAL HISTORY

Patient Name:			Date of Birth:
Patient Address:	City:	State:	Zipcode:
Phone Number:	Email Address:		
Patient Representative Name (Responsible Party):		Company (if applicable):	
Address:		Mobile Number:	Work Number:
City:	State:	Zip:	Email Address/Website:

Why are you here today?

Are you having Pain/Discomfort? ☐ **YES** ☐ **NO**	If YES, Where?
Have you been to a Medical Doctor Past 2 Years? ☐ **YES** ☐ **NO**	If **YES**, Medical Doctor's Name
	Doctor's Address / Phone Number
Taken Medication past 2 years? ☐ **YES** ☐ **NO**	Currently take Medication? ☐ **YES** ☐ **NO** / If **YES**, List Medication
Are you **Allergic** to Medication? ☐ **YES** ☐ **NO**	If **YES**, List Medication/Substance

Please answer the following questions to the best of your ability:

When you walk up stairs or take a walk, do you have to stop because of pain in your chest, shortness of breath, or very tired?	☐ **YES** ☐ **NO**		
Are you on a special diet?	☐ **YES** ☐ **NO**	Do your ankles swell during the day?	☐ **YES** ☐ **NO**
Do you use more than 2 pillows to sleep?	☐ **YES** ☐ **NO**	Do you wake up from sleep and feel short of breath?	☐ **YES** ☐ **NO**
Have you lost or gained more than 10 pounds in the past year?	☐ **YES** ☐ **NO**		
Has medical doctor ever said you have cancer or a tumor?	☐ **YES** ☐ **NO**	If **YES**, where?	
Do you use Tobacco Products? *(smoking or chewing tobacco)*	☐ **YES** ☐ **NO**	If **YES**, how often and how much?	
Do you drink alcoholic beverages?	☐ **YES** ☐ **NO**	If **YES**, how often and how much?	

Continued Next Page ➡

MEDICAL AND DENTAL HISTORY CONTINUED

Indicate which of the following you have had or have at present. Select YES or NO for each item.					
Heart Disease and/or Heart Attack	☐ YES ☐ NO	Heart Failure	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Hepatitis C	☐ YES ☐ NO	Kidney Trouble	☐ YES ☐ NO	Arteriosclerosis *(hardening of arteries)*	☐ YES ☐ NO
Angina Pectoris	☐ YES ☐ NO	High Bloor Pressure	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Congenital Heart Disease	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO	HIV/AIDS	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Blood Transfusion	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO	Cold Sores/Fever	☐ YES ☐ NO	Cortisone Medication	☐ YES ☐ NO
Heart Pacemaker	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Cosmetic Surgery	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Anemia	☐ YES ☐ NO	Sickle Cell Disease	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO	Bruise Easily	☐ YES ☐ NO	Yellow Jaundice	☐ YES ☐ NO
Liver Disease	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO	Rheumatism	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Epilepsy or Seizures	☐ YES ☐ NO	Fainty or Dizzy Spells	☐ YES ☐ NO
Allergies or Hives	☐ YES ☐ NO	Nervousness	☐ YES ☐ NO	Chemotherapy	☐ YES ☐ NO
Sinus Trouble	☐ YES ☐ NO	Radiation Therapy	☐ YES ☐ NO	Drug Addiction	☐ YES ☐ NO
Pain in Jaw/Joints	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO	Psychiatric Treatment	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Hepatitis A (infectious)	☐ YES ☐ NO	Hepatitis B (serum)	☐ YES ☐ NO
Do you have a disease or condition not listed?	☐ YES ☐ NO	If **YES**, list here:			
FOR WOMEN ONLY					
Are you currently pregnant?	☐ YES ☐ NO	Are you nursing?	☐ YES ☐ NO	Are you taking birth control pills?	☐ YES ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. **By signing (below), I have agreed that all questions have been answered truthfully.**

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

REVIEW DATE	CHANGE IN HEALTH	PATIENT SIGNATURE	DENTIST SIGNATURE

David M. Kimler Dentistry, PLLC

6500 Stage Road Suite 1 • Bartlett, TN 38134 • 901-362-9995

PATIENT INTAKE FORM

Patient Name: _____

Address: _____

Social Security Number: _____ - _____ - _____ DOB: _____ Sex: **M F**

Organ Donor: **Yes No Unknown** Advanced Care Plan: **Yes No Unknown**

Contact Name to Confirm Appointments: _____

Phone: _____ Email: _____

Medication List

_____

_____

_____

_____

Name of Independent Support Coordinator (ISC) and AGENCY:

_____

Signature: _____ Date: _____

David M. Kimler Dentistry, PLLC

6500 Stage Road Suite 1 ● Bartlett, TN 38134 ● 901-362-9995

CONSENT FOR SEDATION & DENTAL TREATMENT

The surgical procedure that is to be performed has been explained to me and I understand the nature of my condition and of the proposed treatment. I also understand what health risks exist if the procedure is not done. This is my consent to the surgery. I also understand that with this procedure that there could be follow-up appointments. My consent is valid for all appointments within one year of today's date (listed below).

I agree to the administration of sedation, anesthesia, or therapeutic measures as previously discussed that may be necessary for my comfort, safety, and/or well-being. I understand that the course of my treatment could require multiple anesthetic treatments.

It has been explained that with IV administrations, there is occasional inflammation and discomfort with a vein. There is the possibility of injury to or stiffness of the neck and facial muscles and also changes in the occlusion or temporomandibular joint. In some cases, there is injury to adjacent teeth, referred pain to the ear, neck and head, nausea, allergic reactions, bone fractures, delayed healing and permanent numbness of the nerves in the facial area. Sinus complications which may occur from the removal of upper teeth include a root tip or tooth in the sinus or development of a lingering opening into the sinus from the mouth which could require sinus treatments following oral surgery.

Medications given during or after surgery may cause drowsiness and lack of awareness and coordination which could be increase by the use of alcohol and/or drugs. I have been advised not to operate any vehicle or hazardous devices while taking such medications for at least 24 hours or until recovered from the affects.

I realize that some of the potential complications can be avoided or reduced by carefully following the doctor's instructions. I have had an opportunity to ask questions about the procedure and aspects related to it and have them answered to my satisfaction.

Patient Name / Responsible Party	Date
Signature / Responsible Party	Valid Until Date *(1 year from sign date)*

State of Tennessee
Department of Intellectual and Developmental Disabilities

DISCRIMINATION IS PROHIBITED

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 REQUIRES THAT FEDERALLY ASSISTED PROGRAMS BE FREE OF DISCRIMINATION. THE TENNESSEE DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ALSO REQUIRES THAT ITS ACTIVITIES BE CONDUCTED WITHOUT REGARD TO RACE, AGE, COLOR OR NATIONAL ORIGIN.

Prohibited Practices Includes:

- Denying an individual any services, opportunity, or other benefit for which they are otherwise qualified,
- Providing any individual with any service or other benefit, or is different or is provided in a different manner from that which is provided to others under the program,
- Subjecting any individual to segregated or separate treatment in any manner related to their receipt of service,
- Restricting any individual in any way in the enjoyment of services, facilities, or any other advantage, privilege, or benefit provided to others under the program,
- Adopting methods of administration that would limit participation by any group of persons supported or subject them to discrimination,
- Addressing an individual in a manner that denotes inferiority because of race, color, or national origin,
- Subjecting any individual to incidents of racial or ethnic harassment, the creation of a hostile racial or ethnic environment, and disproportionate burden of environmental health risks on minority communities.

Should you feel you have been discriminated against, please contact the local Title VI coordinator.

Name: **Beth Horton** Title: **Administrator**

Address: **6500 Stage Road, Ste. 1 Bartlett, TN 38134**

Phone: **(901) 362-9995** Fax: **(901) 368-1112**

Any individual may file a Title VI complaint with the below listed entities. It is preferable that complaints be registered at the local level first.

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISIABILITIES
Title VI Compliance Director
Vickey Coleman, Ph.D.
315 Deaderick Street
Nashville, TN 37243

OR

U.S. DEPARTMENT OF JUSTICE COORDINATION & REVIEW SECTION
NYA CIVIL RIGHS DIVISION
950 Pennsylvania Avenue, N.W.
Washington, DC 20530
(888) 848-5306 (toll free voice and TDD)

		Dr. David M. Kimler, D.D.S.	
Person Supported	Date	Service Provider	
		Beth Horton	
Legal Representative	Date	Agency Representative	Date

State of Tennessee
Department of Intellectual and Developmental Disabilities
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information (PHI) as described below. I understand that this authorization is voluntary, and **I may refuse to sign it**. I understand that if the person authorized to receive the information is not a health plan or health care provider, the release information may no longer be confidential under Tennessee Code Annotated 33-3-104 or prohibited by federal privacy regulations, Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Service Recipient's Name: _____ D.O.B: _____

Facility Providing the Information: (Name/Address)	Person/Organization Receiving Information: (Name/Address/Waiver of Services if Applicable)
Department of Intellectual and Developmental Disabilities (WTRO)	**David M. Kimler Dentistry, PLLC**
11437 Milton Wilson Rd.	**6500 Stage Road, Suite 1**
Arlington, TN 38002	**Bartlett, TN 38134**

Specific description of and purpose for the information including date(s) to be provided:

To provide summary profiles, psychological evaluation, and identifying information on this individual for the purpose of determining eligibility for support services through Intellectual and Developmental Disabilities (DIDD).

The service recipient or the service recipient's parent/guardian (if minor), conservator, or legal representative must read and sign below understanding the following:

- I understand that my health care, eligibility for health care, or the payment for my health care will not be affected if I sign this form.
- I understand that I may see and copy the information described in this form, if I ask for it, and that I get a copy of this form after I sign.
- I understand that this authorization will expire on _____.
  If no date is specified, this authorization will expire ninety (90) days from the date of signature below.
- I understand that I may revoke this authorization at any time by notifying the person/organization in writing, but if I do, it will not have any affect on any actions taken BEFORE I request to revoke the authorization.
- I understand that if requested, the facility has thirty (30) days in which to provide a copy of my records, and if records are stored off the premises sixty (60) days.

_____ _____

Signature of Service Recipient, Parent/Guardian Conservator or Representative — Date of Signing

Printed Name of Service Recipient's Representative: _____

Relationship to Service Recipient: _____