



Columbia Periodontics

Experienced, compassionate care for excellent oral health

James L. Dickson, DDS

*Doctor of Dental Surgery:
College of Dentistry,
University of Tennessee
Health Center, Memphis, TN*

*Residency: Periodontology,
University of Kentucky,
Lexington, KY*

*Over 35 years of periodontal
excellence:*

- Nonsurgical periodontics
- Dental implants
- Antibiotic therapy
- Guided tissue regeneration
- Radiosurgery
- PROPHY-JET® ultrasonics

*We make your care
comfortable &
convenient:*

- IV sedation
- Oral conscious sedation
- Most insurance accepted & filed
- CareCredit® patient financing available
- Visa & MasterCard accepted
- Same-day emergency appointments
- Lunchtime appointments
- No-wait appointments
- Handicapped-accessible

Confidential Patient Information

PLEASE PRINT

Patient's Name: _____ Date Of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell: (_____) _____

Work: (_____) _____ Social Security Number: _____ - _____ - _____

E-Mail Address: _____

Employer Name: _____

Occupation: _____

Parent/Spouse Name: _____

Social Security Number: _____ - _____ - _____ Date Of Birth: _____

Spouse's Employer: _____

Dental Insurance

Your Dental Insurance Carrier: _____

Spouse's Dental Insurance Carrier: _____

PLEASE HAVE YOUR DENTAL INSURANCE CARDS FOR US TO COPY

Once an appointment has been made, please remember this time has been reserved for you, the patient. We ask you to give us 48 hours in advance for any cancellations.

Kindly give us one week's notice to reschedule long procedures.

Dental Care

Whom may we thank for referring you? _____

When was your last dental visit? _____

When were x-rays last taken? _____

931-380-1101

104 Berrywood Drive • Columbia, TN 38401 • Across from Maury Regional Hospital • Fax 931-380-9172

www.columbiaperiodontics.com



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Physician's Care

Are you under the care of a physician? Yes No

Purpose: _____

Physician's Name: _____

Phone: _____

Are You Allergic to any medications? If so please list: _____

Please list any medication you are now taking or have taken in the last 12 months: _____

Please circle the correct response

Have you ever had an injury to face or jaws?	Y	N
Have you ever been treated for a growth or tumor?	Y	N
Have you ever been seriously ill?	Y	N
Have you ever had surgery?	Y	N
Has there been any change in your health in the past year?	Y	N
Have you ever been hospitalized?	Y	N
Do you feel good?	Y	N
Do you use tobacco products	Y	N

Please circle any condition that you have or have had

High Blood Pressure	Heart Disease	AIDS/HIV	Artificial Joints
Low Blood Pressure	Asthma	Alcoholism	Tuberculosis
Diabetes	Pace Maker	Epilepsy	Teeth Clenching Habit
Rheumatic Fever	Fainting	Kidney Disease	Prolonged Bleeding
Angina	Hepatitis A, B or C	Smoking	Cancer
Heart Surgery (Bypass or Valve Replacement)			

For All Patients

"I authorize this dentist to release any and all information acquired in the course of my examination or treatment and permit him, any benefits due me from my insurance carrier for his service. I also accept personal responsibility for any balance acquired in my treatment regardless of the insurance Benefit determinations."

Patient or Guardian Signature: _____

Date: _____

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