623 E. Main Street · Hendersonville, TN 37075 · 615-822-3115

PATIENT INFORMATION

Patient SSN: ____________________

Name: ____________________ Preferred: ____________________

Gender: ☐Male ☐Female Birthdate (MM/DD/YYYY): ____________________ Age: __________

Address: ____________________ City: ____________________ State: __________

Zip: __________ Home Phone: ____________________ Work Phone: ____________________

Email: __________ Cell Phone: ____________________ Addt'l Phone: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Parent/Spouse SSN: ____________________

Parent/Spouse Name: ____________________ Preferred: ____________________

Gender: ☐Male ☐Female Birthdate (MM/DD/YYYY): ____________________ Age: __________

Email: __________ Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Addt'l Phone: ____________________

EMPLOYER INFORMATION

Employer: ____________________ Position: ____________________

Address: ____________________ City: ____________________ State: __________

Zip: __________ Best time of day to call you: ____________________

Parent/Spouse Employer: ____________________ Position: ____________________

Address: ____________________ City: ____________________ State: __________

Zip: __________ Best time of day to call you: ____________________

INSURANCE INFORMATION

Primary Insurance: ____________________ Phone: ____________________

Address: ____________________

Group Number: ____________________ Subscribers ID Number: ____________________

Subscribers Name: ____________________ Subscribers Birthdate (MM/DD/YYYY): ____________________

Subscribers Employer: ____________________

Secondary Insurance: ____________________ Phone: ____________________

Address: ____________________

Group Number: ____________________ Subscribers ID Number: ____________________

Subscribers Name: ____________________ Subscribers Birthdate (MM/DD/YYYY): ____________________

Subscribers Employer: ____________________

MEDICAL HISTORY

Are you currently under the care of a physician: Yes or No Date of last visit: ____________

Physicians Name: ____________ Phone Number: ____________

Explain: ____________

Rate your Current Health: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are you taking any persciption/over-the-counter drugs or supplements? ____________

Have you ever taken Fosamax® or any other bisphosphonate: Yes or No

Women

Are you taking any medical contraceptives: ☐ Yes ☐ No

Are you pregnant: ☐ Yes ☐ No Weeks: ____________ Are you nursing: ☐ Yes ☐ No

HEALTH HISTORY

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No Acid Reflux
☐ Yes ☐ No Alcohol / Drug Abuse
☐ Yes ☐ No Anemia
☐ Yes ☐ No Artificial Bones / Joints / Valves
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer / Chemotherapy
☐ Yes ☐ No Colitus
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No Dry Mouth
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Facial Muscle Soreness
☐ Yes ☐ No Fainting Spells
☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Grinding / Clenching Teeth
☐ Yes ☐ No Hay Fever
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Surgery
☐ Yes ☐ No Headache / Migraines
☐ Yes ☐ No Hemophelia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Herpes / Fever Blisters
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No HIV+ / AIDS
☐ Yes ☐ No Hospitalized for any reason
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Pop / Clicking of Jaw
☐ Yes ☐ No Psychiatric Problems
☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Rhuematic / Scarlet Fever
☐ Yes ☐ No Seizures
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sickle Cell Disease / Traits
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tooth Pain
☐ Yes ☐ No TMJ Problems
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease

List any serious medical condition(s) that you have ever had:

____

____

____

ALLERGIES

Are you allergic to any of the following:

☐ Yes ☐ No *Aspirin*	☐ Yes ☐ No *Erytheromycin*	☐ Yes ☐ No *Metals*
☐ Yes ☐ No *Codeine*	☐ Yes ☐ No *Jewelry*	☐ Yes ☐ No *Penicillin*
☐ Yes ☐ No *Dental Anesthetics*	☐ Yes ☐ No *Latex*	☐ Yes ☐ No *Tetracycline*

Please list any additional allergies

____

TODAYS VISIT

Previous Dental Office: ______________________ Phone: ______________

Last Visit: ____/____/____ Last Cleaning: ____/____/____ Last X-Rays: ____/____/____

Why have you come into our office today:

____

Do your gums ever bleed: ☐ Yes ☐ No Do you require antibiotics before treatment: ☐ Yes ☐ No

Rate Your Current Dental Discomfort:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you ever had serious / difficult problems associated with previous dental work?

____

Have you ever experienced pain discomfort in your jaw joint (TMJ / TMD): ☐ Yes ☐ No

Do you smoke or use tocacco in any form? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

SMILE ASSESSMENT

Do you like your smile? ☐ Yes ☐ No

What would you like to change: ______________________

____

Would you like whiter teeth? ☐ Yes ☐ No Base line shade (offical use only): ______________

Do you use an electric toothbrush? ☐ Yes ☐ No Type: ______________

How did you hear about us?

☐ Mailing (Letter)	☐ Mailing (Postcard)	☐ Welcome Wagon	☐ Web Search
☐ Referred by:	☐ Event	☐ Email Blast (title)	☐ Other
______________	______________	______________	______________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform the office in any changes to medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature: ____