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AESTHETIC & RESTORATIVE DENTISTRY

615.771.1999 | WWW.YourConfidentSmile.com

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

Patient Information

Date _____

Name _____ SS# _____

Home Phone _____ Cell Phone _____ Email Address _____

Address _____ City _____ State _____ Zip _____

Sex _____M _____F Age _____ Birthdate _____ _____ Single _____ Married _____Other

Patient Employed By _____ Occupation _____ Business Phone _____

In case of emergency who should we contact? _____ Phone _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Person Responsible For Account _____

Relation to Patient _____ Birthdate _____ SS # _____

Address (if different from patients) _____ Phone # _____

Employer _____ Work Phone # _____

Insurance Company _____ Contact # _____ Group # _____

Subscriber # (if different than SS#) _____ Do you have other dental insurance? _____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

TO BETTER SERVE YOU

Reason for Today's Visit _____

Date of Last Dental Treatment _____ Date of Last Dental X-Rays _____ Former Dentist _____

If you could change something about your smile, what would it be? _____

DENTAL HISTORY

Please check if you have recently experienced any of the following:

Bad Breath	Grinding Teeth	Sensitivity to Heat
Bleeding Gums	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Clicking of Popping Jaw	Periodontal Treatment	Sensitivity When Biting
Food Collection Between Teeth	Sensitivity to Cold	Sores or Growths in Your Mouth

How Often Do You Floss?_____

How Often Do You Brush? _____

Do You Have Any Other Concerns? _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit_____

Do you require an antibiotic before dental treatment? Yes No

Have You Had Any Serious Illness or Operations: Yes No If Yes, Please Describe_____

Have You Ever Had A Blood Transfusion? Yes No If Yes, Approximate Date(s)_____

Are You Pregnant? Yes No Nursing Yes No Taking Birth Control Pills Yes No

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS	Cough, Persistent	High Blood Pressure	
Anemia	Cough up Blood	HIV Positive	Skin Rash
Arthritis	Diabetes	Jaw Pain	Stomach Problems
Artificial Heart Valve	Epilepsy	Kidney Disease	Stroke
Artificial Joints	Excessive Bleeding	Liver Disease	Swelling of Feet or Ankles
Asthma	Fainting	Mitral Valve Prolapse	Thyroid Problems
Back Problems	Glaucoma	Nervous Problems	Tobacco Habit
Blood Disease	Headache	Pacemaker	Tuberculosis
Cancer	Heart Murmur	Radiation Treatment	Ulcer
Chemical Dependency	Heart Problems	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilia	Rheumatic Fever	Any Other Conditions not listed
Cortisone Treatment	Hepatitis	Shortness of Breath	_____

PLEASE LIST ALL ALLERGIES:

_____

_____

_____

_____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY ON:

_____

_____

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_____