Nashville Center for Aesthetic Dentistry

WELCOME

Today's Date____________________________

Name____________________________

I prefer to be called ____________________________

Birthdate ____________________ ❍ Male ❍ Female

Home Address ____________________________

____________________________ Zip__________

Home phone ____________________ Work phone____________________

Cellular phone ____________________________

E-Mail ____________________________

How did you find out about our office?____________________________

Employer ____________________________

Occupation ____________________________

Spouse Name ____________________________

His/Her Employer ____________________________

Person to contact in case of an emergency:

Name: ____________________ Phone:____________________

DENTAL INSURANCE

Insurance Co. Name ____________________________

Insurance Co. Address ____________________________

____________________________ Zip__________

Insurance Co. Phone ____________________ Group/Plan #____________________

Insured's Name____________________________

Relation (circle one) self spouse child other ____________________

Insured's Birthdate ____________________ Insured ID # (or SS #)____________________

Insured's Employer____________________________

OVER

MEDICAL INFORMATION

Do you have a personal physician? YES NO

Physician's Name______________________________

Your current health is GOOD FAIR POOR

Are you currently taking prescription or over-the-counter medications? YES NO

Please list______________________________

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For Women:

Are you pregnant? YES NO

Are you nursing? YES NO

Have you ever had any of the following diseases or medical conditions?

Y	N	Abnormal Bleeding	Y	N	Hepatitis B or C
Y	N	Acid Reflux	Y	N	Cold Sores/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hypoglycemia
Y	N	Artificial Joints/Bones/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Leukemia
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer	Y	N	Low Blood Pressure
Y	N	Chemotherapy	Y	N	Lung Disease
Y	N	Colitis	Y	N	Migraines
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy/Seizures	Y	N	Rheumatic Fever
Y	N	Fainting Spells	Y	N	Scarlet Fever
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis A			

Do you need to be premedicated for Mitral Valve Prolapse or Heart Murmur? YES NO

Please circle any of the following which you are allergic to:

Aspirin	Erythromycin	Sulfa Drugs
Codeine	Latex	Tetracycline
Dental Anesthetics	Penicillin	

Other (please list): ______________________________

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DENTAL INFORMATION

Previous/Present Dentist ______________________________

Last Visit Date ______________________________

Your current dental health is GOOD FAIR POOR

Y N Do you feel you are meticulous with your oral hygiene?

Y N Do you understand the correlation between plaque control and the prevention of gum disease?

Y N Do you grind your teeth at night?

Y N Have you ever had pain/discomfort in your jaw joint?

Y N Would you like to keep your natural teeth for as long as you live?

Y N Do you get frustrated that you need work done every time you go to the dentist?

Y N Would you like to have whiter teeth?

Y N Are your teeth prone to getting cavities (decay)?

Y N Do you have silver or discolored fillings that you are unhappy with?

Y N Do you have crowns or bridges which are unattractive or unnatural-looking?

Y N Do you sometimes feel uncomfortable with the appearance of your smile?

Y N Are your teeth crooked or crowded?

Y N Would you like them to be straighter?

Y N Do you have one or more missing teeth?

Y N Do you have unattractive spaces between your teeth?

Y N Do you think a more attractive smile would improve your personal and/or professional relationships?

Y N Do you often feel as if your breath is not as fresh as it could be?

Y N Would you like to hear about how your breath can be its freshest?

What level of dental care do you think your dental insurance company pays for?

Poor Fair Excellent

What level of dental care would you like to have for yourself?

Poor Fair Excellent

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my 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.

Signature______________________________ **Date**______________________________