Welcome!

Creekside Family Dental Center

706 Lion Parkway ♦ Columbia, TN 38401
Phone: 931-388-3384
Fax: 931-388-1250

1 ABOUT YOU

Today's Date: ____/____/____

★ **Patient's Name:** _____

What You Prefer to be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____

Soc. Sec. # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____

Home Phone: (_____) _____ Ext. _____

Work Phone: (_____) _____

★ **E-mail Address:** _____

Best Way to Confirm Appointment: ❑ **Call** ❑ **Text** ❑ **E-mail**

Referred By: _____

★ **EMPLOYER:** _____ How Long? _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

2 INSURANCE INFO

Primary Dental Insurance

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Insured's Soc. Sec. No. _____

Group No. (Plan, Local, or Policy No.): _____

Insured's Name: _____

Relationship: _____ Date of Birth: ____/____/____

★ **Insured's Employer:** _____

Secondary Dental Insurance

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Insured's Soc. Sec. No. _____

Group No. (Plan, Local, or Policy No.): _____

Insured's Name: _____

Relationship: _____ Date of Birth: ____/____/____

★ **Insured's Employer:** _____

3 ACCOUNT INFO

Person ultimately responsible for account:

Name: _____

Relationship: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Soc. Sec. No. _____

Driver's License No. _____

Work Phone No. (_____) _____

Payment Method: ❑ Cash ❑ Check

_____ INITIALS I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

4 IN EVENT OF EMERGENCY

Whom should we contact in case of emergency:

Name: _____

Relationship: _____

Home Phone: (_____) _____

Work Phone: (_____) _____ Ext. _____

Cell Phone: (_____) _____

Who is your medical doctor?

Name: _____

Phone No. (_____) _____

Please Continue on Back ▸▸▸

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Lost/Broken Filling(s) ❑ Stained teeth ❑ Bad breath
❑ Red, swollen or bleeding gums ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums ❑ Ringing in Ears ❑ Other:_____
❑ Blisters/Sores in or around the mouth ❑ Broken/ Chipped Tooth

Previous Dentist:_____ Phone: (_____) _____

Last Dental Exam: _____/_____/_____ Last Dental X-Rays: _____/_____/_____

How many times do you brush each day?_____ How many times do you floss each week?_____

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 MEDICAL HISTORY

Do you require antibiotics before dental treatment? ❑ Yes ❑ No ❑ Don't Know

Please check yes or no to the following:

1. Are you under a physician's care now? ❑ Yes ❑ No Explain:_____
2. Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No Explain:_____
3. Have you ever had a serious head or neck injury? ❑ Yes ❑ No Explain:_____
4. Are you taking any medications, pills or drugs? ❑ Yes ❑ No If Yes, please list:_____
5. Are you on an aspirin regimen or taking any type blood thinner? ❑ Yes ❑ No If Yes, please list:_____
6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No
7. **Women:** Are you pregnant/trying to get pregnant? ❑ Yes ❑ No ❑ Nursing Taking oral contraceptives? ❑ Yes ❑ No ❑ N/A

Do you use tobacco? ❑ Yes ❑ No ❑ N/A Do you use controlled substances? ❑ Yes ❑ No ❑ N/A

If you are allergic to any of the following, please circle: Aspirin Penicillin Codeine Acrylic Metal Latex/Vinyl Local Anesthetics

Other:_____

Please indicate if you have or have ever had any of the following:

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Arthritis / Gout
❑ **Artificial Heart Valve**
❑ **Artificial Joint**
❑ Asthma
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting Spells/Dizziness
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Frequent Headaches
❑ Genital Herpes
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pacemaker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ **Mitral Valve Prolapse**
❑ Osteoporosis
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatments
❑ Recent Weight Loss
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Spinal Bifida
❑ Stomach/Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tonsilitis
❑ Tuberculosis
❑ Tumors or Growths
❑ Ulcers
❑ Venereal Disease
❑ Yellow Jaundice

Have you had any other serious illness not listed above? ❑ Yes ❑ No Comments:_____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

❑ Adult Patient
❑ Parent or Guardian Signature_____ Date_____/_____/_____
❑ Spouse