WELCOME TO OUR PRACTICE

Dr. David K. Andrews, DDS, PLLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your dental health.

Patient Information

Today's Date _____

Name _____ Soc. Sec. # _____
Last name *First name* *Initial*

Address _____

City _____State _____ Zip _____ Home Phone _____

Cell Phone _____ E-mail Address _____

Sex: M F Age _____ Date of Birth _____ Single Married Widowed Separated Divorced
(Circle one)

Patient Employed by _____

Business Address _____ Phone # _____

Whom may we thank for referring you? _____

Notify in Case of Emergency _____ Home Phone _____

Cell Phone _____ Relationship to Patient_____

Person Responsible for Account _____
Last name *First name* *Initial*

Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ E-mail Address_____

Person Responsible Employed by _____

Business Address _____ Business Phone _____

Primary Insurance

Subscriber Name _____ Subscriber ID _____ Date of Birth _____

Group # _____ Insurance Company _____ Phone # _____

Additional Insurance

Is patient covered by additional insurance? Yes No (circle one)

Subscriber Name _____ Relation to patient _____ Date of Birth _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home phone _____

Subscriber employed by _____ Business Phone _____

Insurance Company _____ Phone # _____

Subscriber ID _____ Group # _____

Dental History

What would you like us to do today? _____Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Tel. # _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❒ Y❒ N Bad breath ❒Y❒ N Food collection between teeth ❒Y❒ N Periodontal treatment ❒Y ❒ N Sensitivity to sweets
❒ Y❒ N Bleeding gums ❒Y❒ N Grinding or clenching teeth ❒Y ❒ N Sensitivity to cold ❒Y ❒ N Sensitivity when biting
❒ Y❒ N Clicking or popping jaw ❒Y❒ N Loose teeth or broken fillings ❒Y❒ N Sensitivity to hot ❒Y❒ N Sores or growths in mouth

How often do you brush? _____ How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❒ Y ❒ N
Other information about your dental health or previous treatment _____

Medical History

Physician's name _____Phone # _____
Date of last visit _____Have you had any serious illnesses or operations? ❒ Y ❒ N
If yes, please describe _____
Are you currently under a physician's care? ❒ Y ❒ N If yes, explain _____
Have you ever had a blood transfusion? ❒ Y ❒ N If yes, list approximate dates _____
Have you ever taken Fen-Phen/Redux? ❒ Y ❒ N Have you ever used Fosamax, Actonal, Atelvia, Didronal, Boniva? ❒ Y ❒ N
Women: Are you pregnant? ❒ Y ❒ N Nursing? ❒ Y ❒ N Taking birth control ❒ Y ❒ N
Check (✓) yes or no to whether you have had any of the following:

❒Y❒ N ADD/ADHD
❒Y❒ N AIDS/HIV Positive
❒Y❒ N Anemia
❒Y❒ N Arthritis, Rheumatism
❒Y❒ N Artificial heart valves/stints When?
❒Y❒ N Asthma
❒Y❒ N Allergies/Sinus
❒Y❒ N Back Problems
❒Y❒ N Blood Disease
❒Y❒ N Cancer
❒Y❒ N Chemical dependency
❒Y❒ N Chemotherapy
❒Y❒ N Circulatory problems

❒Y❒ N Cortisone treatments
❒Y❒ N Cough, persistent
❒Y❒ N Cough up blood
❒Y❒ N Diabetes
❒Y❒ N Epilepsy/Seizures
❒Y❒ N Fainting
❒Y❒ N Food Allergies
❒Y❒ N Glaucoma
❒Y❒ N Headaches
❒Y❒ N Heart Murmur/MVP
❒Y❒ N Heart issues/Stroke Describe
❒Y❒ N Hemophilia/ Abnormal bleeding

❒Y❒ N Herpes or Cold Sores
❒Y❒ N Hepatitis A,B,C
❒Y❒ N High Blood pressure
❒Y❒ N Jaw pain
❒Y❒ N Kidney disease
❒Y❒ N Latex allergy
❒Y❒ N Liver Disease
❒Y❒ N Nervous problems
❒Y❒ N Pacemaker/Heart surgery When?
❒Y❒ N Psychiatric care
❒Y❒ N Rapid weight loss/gain
❒Y❒ N Radiation treatment
❒Y❒ N Respiratory Disease

❒Y❒ N Rheumatic/Scarlet fever
❒Y❒ N Shingles
❒Y❒ N Shortness of breath
❒Y❒ N Skin rash
❒Y❒ N Special Needs
❒Y❒ N Spinal Bifida
❒Y❒ N Swelling of feet/ankles
❒Y❒ N Thyroid Disease
❒Y❒ N Tobacco habit
❒Y❒ N Tonsillitis
❒Y❒ N Tuberculosis
❒Y❒ N Ulcer/Colitis
❒Y❒ N Venereal Disease
Other:

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have **drug allergies**? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist 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 financially responsible for all charges whether or not paid by insurance (with the exception of TennCare)

Patient/Guardian's Signature _____ Date _____