WELCOME

RONALD A. LEWIS, D.D.S.
FAMILY DENTISTRY

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(615) 859-2276

1 ABOUT YOU

Today's Date: ____/____/____

Patient's Name: ____________________ (LAST / FIRST / M.I.)

What you perfer to be called: ________ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ______

Social Security #: ____________________

Mailing Address: ____________________

____________________ (CITY / STATE / ZIP)

Home Phone #: (______)____________

Work Phone #: (______)____________ Ext:______

Cell Phone #: (______)____________

E-mail Address: ____________________

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

Company Name: ____________________

Address: ____________________

____________________ (CITY / STATE / ZIP)

Phone #: (______)____________

Insured's Social Security #: ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: ____________________

Relation: ____________ Date of Birth: ____/____/____

Insured's Employer: ____________________

Secondary Dental Insurance

Company Name: ____________________

Address: ____________________

____________________ (CITY / STATE / ZIP)

Phone #: (______)____________

Insured's Social Security #: ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: ____________________

Relation: ____________ Date of Birth: ____/____/____

Insured's Employer: ____________________

3 ACCOUNT INFO

Person ultimately responsible for account

Name: ____________________

Relation: ____________________

Billing Address: ____________________

____________________ (CITY / STATE / ZIP)

Social Security #: ____________________

Drivers License #: ____________________

Work Phone #: (______)____________

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.

Signature: ____________________ Date: ____/____/____

4 EMERGENCY INFO

In event of an emergency, whom should we contact? ____________

____

Relation: ____________________

Home Phone #: (______)____________

Work Phone #: (______)____________

Cell Phone #: (______)____________

Who is your medical doctor? ____________________

Medical doctor's phone #: (______)____________

Doctor's address: ____________________

____________________ (CITY / STATE / ZIP)

PLEASE COMPLETE REVERSE SIDE ALSO

5 DENTAL INFO

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ Yes ☐ No If yes, how long? ______

Please indicate ☑ any of the following problems:

☐ Discomfort, Clicking or Popping in Jaw
☐ Red, Swollen or Bleeding Gums
☐ Sensitive Tooth, Teeth or Gums
☐ Blisters/Sores in or Around the Mouth
☐ Lost/Broken Filling(s)
☐ Teeth Grinding
☐ Ringing in Ears
☐ Broken/Chipped Tooth
☐ Stained Teeth
☐ Locking Jaw
☐ Bad Breath

Describe (or other): ______

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know If yes, what? ______

Previous dentist: ______ Phone: (____)______

Last dental exam: ____/____/____ Last dental x-rays: ____/____/____

Times a day you brush? ______ Times a week you floss? ______

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

How would you rate the your smile? **WORST** 1 2 3 4 5 6 7 8 9 10 **BEST**

6 MEDICAL HISTORY

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Others (please list): ______

Do you have or ever had any of the following diseases, medical conditions or procedures? (Circle **Y** or **N**)

Y N Heart Attack/Stroke
Y N Heart Surg./Pacemaker
Y N Heart Murmur
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Chest Pains
Y N Scarlet Fever
Y N Nervousness
Y N Thyroid Problems
Y N Kidney Problems
Y N Liver Problems
Y N Respiratory Problems
Y N Sinus Problems
Y N Stomach Problems/Ulcers
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Tuberculosis TB
Y N Jaw Problems TMJ/TMD
Y N Cancer/Tumors
Y N Shingles
Y N Hepatitis
Y N HIV+/AIDS/ARC
Y N Arthritis/Rheumatism
Y N Joint Replacements
Y N Emphysema
Y N Fainting/Seizures/Epilepsy
Y N Severe/Frequent Headaches
Y N Frequent Neck Pain
Y N Back Problems
Y N Pins/Plates/Screws
Y N Xray or Cobalt Treatment
Y N Chemotherapy
Y N Asthma
Y N Difficulty Breathing
Y N Diabetes/Hypoglycemia
Y N Leukemia
Y N Anemia
Y N High/Low Blood Pressure
Y N Bleeding Problems
Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ______

______

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxycillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Other(s): ______

Do you use tobacco? ☐ Yes ☐ No If yes, how used? ______ How much? ______ How long? ______

Please rate your general health from 1-10: ______ Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and/or Redux? ☐ Yes ☐ No If yes, have you had your heart checked? ☐ Yes ☐ No

If yes, by whom? ______

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due date? ______ Are you nursing? ☐ Yes ☐ No

- 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.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- 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 correctly 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.

Signature: ______ Date: ____/____/____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE
(OFFICE USE)

______ Initials ____/____/____ Date
______ Comments

______ Initials ____/____/____ Date
______ Comments

______ Initials ____/____/____ Date
______ Comments