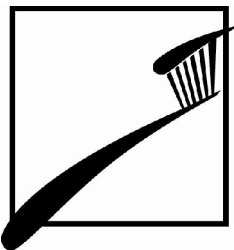


The Nashville Smile Team



Kristin Rushing, DDS
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Nashville, TN 37220
331-9033

www.NashvilleSmileTeam.com

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____
Address _____ City, State _____ Zip _____
Sex Single Divorced Widowed
 M Married Separated E-mail _____
 F
Home Phone _____ Cell Phone _____ Other _____
Employer _____ Employer Phone _____
Employer Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____ Other Family Members seen by us _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Person Responsible _____ Relation to Patient _____
Address _____ Home Phone _____
Birthdate _____ Currently a patient in our office? Yes No
Employer _____ Work Phone _____
E-mail _____ Cell Phone _____

INSURANCE INFORMATION

Name of Insured _____ Employer _____
Relation to Patient _____ Birthdate _____ Social Security # _____
Insurance Company _____ Group # _____ How much is your deductible? _____
Address _____ City _____ How much have you used? _____
State _____ Zip _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Employer _____
Relation to Patient _____ Birthdate _____ Social Security # _____
Insurance Company _____ Group # _____ How much is your deductible? _____
Address _____ City _____ How much have you used? _____
State _____ Zip _____ Max. Annual Benefit _____

- I authorize payment of insurance benefits directly to the Doctor otherwise payable directly to me.
- I authorize the doctor to release any information relating to my dental services to my insurance company and I understand I am responsible for all costs of dental treatment

Dental History

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Check (✓) if you have or have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw (TMJ) | <input type="checkbox"/> Periodontal treatment / Deep Cleanings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

Would you like whiter teeth? Yes No

What type of toothbrush do you use? Soft Medium Hard

How often do you floss? _____

How often do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List medications you are currently taking: _____

Check (✓) if you have or have had problems with any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Venereal Disease |

Allergies

- | | | | |
|----------------------------------|---|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa | <input type="checkbox"/> None |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |

*To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.*

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____ Relationship to Patient _____

SmileSurvey — If you would kindly answer a few questions below, it would greatly be appreciated. ☺

How do you feel about your smile? _____

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

Is there anything that would keep you from improving your smile? If so, please explain.

Are you familiar with how today's dentistry can enhance your smile? **Yes / No**

Would you like to learn more about how you can improve your smile? **Yes / No**

Thank You!