

**CHAD L. FOLLIS, D.D.S.**  
AESTHETIC & RESTORATIVE DENTISTRY

615.771.1999 | WWW.YOURCONFIDENTSMILE.COM

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

## Patient Information

Cell Phone \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ M \_\_\_\_\_ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_

In case of emergency who should be contact? \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Person Responsible For Account \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address(if different from patients) \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Contact # \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber # (if different than SS#) \_\_\_\_\_ Do you have other dental insurance? \_\_\_\_\_

I authorize my insurance company to pay to the dentist or dental group 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 responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## TO BETTER SERVE YOU

Reason for Today's Visit \_\_\_\_\_

Date of Last Dental Treatment \_\_\_\_\_ Date of Last Denta X-Rays \_\_\_\_\_ Former Dentist \_\_\_\_\_

If you could change something about your smile, what would it be? \_\_\_\_\_

## Dental History

Check if you have any of the following:

Bad Breath	Grinding Teeth	Sensitivity to Heat
Bleeding Gums	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Clickage or Popping Jaw	Periodontal Treatment	Sensitivity When Biting
Food Collection Between Teeth	Sensitivity to Cold	Sores or Growths in Your Mouth

How Often Do You Floss? \_\_\_\_\_

How Often Do You Brush? \_\_\_\_\_

Do You Have Any Other Concerns? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have You Had Any Serious Illness or Operations:    Yes    No    If Yes, Please Describe \_\_\_\_\_

Have You Ever Had A Blood Transfusion?    Yes    No    If Yes Approximate Date(s) \_\_\_\_\_

Are You Pregnant?    Yes    No    Nursing    Yes    No    Taking Birth Control Pills    Yes    No

Do you require antibiotic before dental treatment?    Yes    No

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS	Cough, Persistent	High Blood Pressure	
Anemia	Cough up Blood	HIV Positive	Skin Rash
Arthritis	Diabetes	Jaw Pain	Stomach Problems
Artificial Heart Valve	Epilepsy	Kidney Disease	Stroke
Artificial Joint	Excessive Bleeding	Liver Disease	Swelling of Feet or Ankles
Asthma	Fainting	Mitral Valve Prolapse	Thyroid Problems
Back Problems	Glaucoma	Nervous Problems	Tobacco Habit
Blood Disease	Headache	Pacemaker	Tuberculosis
Cancer	Heart Murmur	Radiation Treatment	Ulcer
Chemical Dependency	Heart Problems	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilia	Rheumatic Fever	Any Other Condition not listed
Cortisone Treatment	Hepatitis	Shortness Of Breath	_____

PLEASE LIST ALL ALLERGIES

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY ON:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



