Cool Springs
1607 Westgate Circle
Suite 400
Brentwood, TN 37027
Ph # : 615-829-7150

NASHVILLE FAMILY DENTISTRY COOL SPRINGS

Patient Personal Information

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics
- ☐ Y ☐ N Other Allergies

Check, if applicable

- ☐ Y ☐ N Angina
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Thinner
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives / Skin Rash
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder disease
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble / Hay Fever
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis

☐ Y ☐ N No Change Since Last Recorded
☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Anemia
☐ Y ☐ N Chest Pain Upon Exertion
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Artifical Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Epilepsy
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse

Treating Providers Only

☐ Y ☐ N Medical History Update

Additional Comments

Dental Questionnaire

Delta Dental

Dental Insurance Carrier: _____

Dental Group Number: _____

Dental Member ID: _____

Subscriber Name and Date of Birth if not the patient : _____

Dental Carrier Phone Number: _____

Complete the full Dental Questionnaire- Check the Yes/No box as appropriate

Name &number of previous Dentist _____

How long ago was your last dental appointment? _____

Do your gums bleed while brushing or flossing ? _____

Do you regularly use dental floss ? _____

Does food catch between your teeth ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you have, or have you ever been told, that you have Periodontal Disease (Gum Disease)? _____

Have one or both of your parents been treated for periodontal disease? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Do you clench or grind your teeth ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you had any head, neck or jaw injuries ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ?	
Are you having any specific problems with your teeth, gums, or mouth at this time ?	
Are you happy with your smile ?	
What would you change about the shape and/or color of your teeth?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

Medical Questionnaire

Family Physician	
Medical Questionnaire Check ONLY if "YES"	
Are you currently under care of a Physician ?	☐
If Yes, what is the condition being treated ?	
Have you had any serious illness, operation or been hospitalized within the past 5 years ?	☐
If Yes, what illness or problem ?	
Please list all medication you are currently taking:	
Pharmacy Name/ Phone Number:	
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	☐
Have you ever taken the diet control drug Fen-Phen ?	☐
Do you consume alcoholic beverages ?	☐
Women Only	
Are you pregnant?	☐
If Yes, what is your due date ?	
Are you currently nursing ?	☐
Are you on hormone replacement therapy ?	☐
Are you on birth control pills / fertility drugs ?	☐
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	
TMJ or Facial Pain Questionnaire(if applicable)	
What is your chief complaint?	
Have you ever had trauma to your head or face?	
Describe Trauma:	
Past Treatment for this pain:	
Do you have headaches?	
If so, are the headaches: mild, moderate or severe?	
If so, are the headaches daily, weekly, monthly or sporadic?	
Do you have clicking or popping in the joint, If so is it left or right or both?	

Have you ever had injections for your facial, TMJ pain?

If yes, what was used?

Do you knowingly clench or grind your teeth?

If yes, is it mostly in the day or night or both?

Current Symptoms: Select: Yes or No:

Headaches under the eyes:

Temporal pain left

Temporal Pain Right

Forehead pain left

Forehead pain right

Head or scalp pain:

Eye pain: above, below or behind:

Blurring Vision:

Light Sensitivity:

Pain in the cheek muscles left:

Pain in the cheek muscles right:

Limited Opening:

Problems chewing or swallowing:

Dry Mouth:

Bleeding gums:

Ringing in the ears:

Pain in the ears:

Neck Pain:

Shoulder pain:

Arm and Finger Tingling, Numbness and Pain:

Breathing Questionnaires/Epworth

Voice changes or scratchiness:

Degree of Current TMJ pain: 0- No pain, 10-Severe Pain

Are you taking any medication specifically for the TMJ or facial pain?

Have you ever been diagnosed with any type of sleep disorder such as sleep apnea:

If so do you wear a CPAP?

Why or why not?

How often do you get up to use the restroom at night?

Do you usually wake feeling tired and unrested?

Do you habitually snore:

Have you been diagnosed with High Blood Pressure?	
Do you regularly experience daytime drowsiness or fatigue?	
Is it difficult to breathe through your nose?	
Has anyone observed you to stop breathing during your sleep?	
Do you ever wake up choking or gasping?	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**