

Lenox Village Dentistry, LLC  
6905 Lenox Village Drive  
Nashville, TN 37211

(615) 832-2095

*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 # \_\_\_\_\_

Date \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

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

Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years Email address \_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_ Cell Phone #1 ( ) \_\_\_\_\_ Cell Phone #2 ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_

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

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

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

Person to contact in case of emergency \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### RESPONSIBLE PARTY

Name of Person \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Responsible for this Account \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Birthdate \_\_\_\_\_ Currently a patient in our office?  Yes  No

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

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

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

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

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

### ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

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

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

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

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

- I authorize payment of insurance benefits directly to the Doctor otherwise payable directly to me, and  
 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 \_\_\_\_\_

Address \_\_\_\_\_

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           | <input type="checkbox"/> Periodontal treatment          | <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 |

How often do you floss \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

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

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

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

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

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

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies:

- |  |   |                                 |                                      |
|--|---|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin       | <input type="checkbox"/> Latex  | _____                                |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            | <input type="checkbox"/> None   |                                      |

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 mindor child, ever have a change in health.

\_\_\_\_\_  
Signature of of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient