

New Patient Information

Dr. Stephen Poss, D.D.S.
1620 Westgate Circle, Suite 250
Brentwood, TN 37027
(615) 373-1056
www.smiles-bydesign.com

Date _____

Last Name First Name Middle Initial

Address Apt/Condo #

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail address Can you receive texts? Yes No

Birthday (Month/Day/Year) Social Security #

Male Female

Drivers License #

Single Married Other

Occupation

Employer

Referred By

Special Interests, Sports, Hobbies

Emergency Contact:

Name Relationship

Phone Number Alternative Number

Dental History:

What brings you to the dental office today? _____

Are you currently in pain? Y N

Approximate date of last dental visit? _____

Have you ever experienced TMJ problems? Y N

Do you grind your teeth? Y N

In your opinion, how would you rate your dental health? Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Medical History:

Do you have a personal physician? Y N

If yes, _____
Name Phone Number

In your opinion, your current physical health is: Good Fair Poor

Do you smoke? Y N

For Women: Are you pregnant? Y N Week # _____

Do you need to be pre-medicated before dental treatment? Y N

Have you had any serious medical problems in the last 5 years? Y N

If yes, please explain: _____

Have you ever had any of the following diseases or medical problems?

- | | | | | | |
|---|---|-----------------------------------|---|---|------------------------------|
| Y | N | Anemia | Y | N | Hemophilia/Abnormal Bleeding |
| Y | N | Cancer/Chemotherapy | Y | N | High/Low Blood Pressure |
| Y | N | Chronic Hepatitis | Y | N | HIV+/AIDS |
| Y | N | Diabetes | Y | N | Kidney problems |
| Y | N | Drug/Alcohol Abuse | Y | N | Psychiatric problems |
| Y | N | Epilepsy/Seizures/Fainting Spells | Y | N | Severe Headaches |
| Y | N | Fever Blisters/Herpes | Y | N | Shingles |
| Y | N | Heart Attack/Stroke | Y | N | Sickle Cell Disease/Traits |
| Y | N | Heart Murmur/Rheumatic Fever | Y | N | Sinus problems |
| Y | N | Heart Surgery/Pacemaker | Y | N | Tuberculosis |

Any other serious medical conditions? _____

Are you allergic to any of the following drugs?

- | | | | | | |
|---|---|--------------------|---|---|--------------|
| Y | N | Aspirin | Y | N | Erythromycin |
| Y | N | Codeine | Y | N | Penicillin |
| Y | N | Dental Anesthetics | Y | N | Tetracycline |

Are you allergic to another other drugs? Y N

If yes, please list _____

How did you hear about Dr. Poss?

friend television billboard
 relative newspaper other dentist
 radio internet if so, who? _____

Please rank the concerns that apply to your feelings about your dental experience in order of importance to you (1= your greatest concern).

Affordability
 Pain
 Final Result
 Time
 Other: _____

Please indicate the area of your oral well-being that concerns you most.

Pain / Discomfort in teeth
 Pain / Discomfort in jaw
 Color
 Shape of teeth
 Metal fillings
 Cracked, chipped or missing tooth

What is the main reason you are here to see Dr. Poss?

Is there a date/ special occasion that we need to be aware of?

Privacy Policy Acceptance Agreement

I, _____, have been supplied with a copy of the active- privacy policies and standards in the office of Dr. Stephen Poss. I have read, understand, and agree to the terms of the privacy policy that has been enacted because of federal HIPAA Laws.

If you currently have dental insurance, please bring your benefits card, so we may make a copy. We will assist you in filing dental claims so that you receive your maximum benefit.

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature

Date

Witness

Date