Drs. Elam, Vaughan and Fleming

A Nashville Tradition of Excellence®

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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

Date_____ Pt. #_____ Home Phone (_____) _____

Name_____ Soc. Sec. # _____
Last Name First Name Initial

Address_____

City_____ State _____ Zip _____

Cell Phone (_____) _____ Email Address _____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation _____

Business Address_____ Business Phone (_____) _____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone (_____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (if different from patient's)_____ Phone (_____) _____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone (_____) _____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance/ ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (if different from patient's)_____ Phone (_____) _____

Subscriber Employed by_____ Occupation_____

Business Address_____ Business Phone (_____) _____

Insurance Company_____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan _____

Please Complete Both Sides

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 had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking 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?_____

Medical History

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, explain_____

Have you had a serious head or neck injury? ☐ Yes ☐ No If yes, explain_____

Are you on a special diet? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

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

Do you have, or have you had, any of the following:

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Congential Heart Disorder	☐ Hay Fever	☐ Leukemia	☐ Sinus Trouble
☐ Anaphylaxis	☐ Convulsions	☐ Heart Attack/Failure	☐ Liver Disease	☐ Spina Bifida
☐ Anemia	☐ Cortisone Medicine	☐ Heart Murmur	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Angina	☐ Diabetes	☐ Heart Pace Maker	☐ Lung Disease	☐ Stroke
☐ Arthritis/Gout	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Artificial Heart Valves	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Artificial Joints	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tonsillitis
☐ Asthma	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Tumors or Growths
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Ulcers
☐ Breathing Problem	☐ Fainting Spells/dizziness	☐ Hives or Rash	☐ Renal Dialysis	☐ Venereal Disease
☐ Bruise Easily	☐ Frequent Cough	☐ HPV-Humanpapillomavirus	☐ Rheumatic Fever	☐ Yellow Jaundice
☐ Cancer	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	
☐ Chemotherapy	☐ Frequent Headaches	☐ Infective Endocarditis	☐ Scarlet Fever	
☐ Chest Pains	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Shingles	

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

List any allergies:

_____

_____

Payment Authorization

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 financially responsible for all charges whether or not paid by insurance.

In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding balances.

Signature_____ Date _____