Edward W. Weakley, DDS
120 Medical Court
Clarksville, TN 37043
(931) 648-8015
www.clarksville-dentist.com

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Patient Information

Name: ____

I prefer to be called: ________________ male female

Married Single Child Divorced Widowed

Birth date: ________________ SSN:_______________

Home Address: ________________________________

____

Hm #:__________________ Cell#:_________________

Wk#:____

Email: ____

Preferred method of communication:

_____phone _____email _____text

Employer: _____________________________________

____

Occupation:____________________________________

Whom may we thank for referring you? ____________

Other family members seen by us? ________________

____

Previous Dentist:_______________________________

Date of Last Visit: ______________________________

In the event of an emergency, who lives nearby that we may contact?

Name: ____

Relation: ______________________________________

Hm #:__________________ Cell#:_________________

Wk#:____

Dental Insurance

Insurance Co. Name: ____________________________

Address: ______________________________________

Phone: ____

Employer: _____________________________________

Group #: ______________________________________

Insured Name: __________________________________

Relation: ______________________________________

Insured's DOB: __________________________________

Insured's SSN / Subscriber #: ______________________

We will help you maximize your insurance benefits and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers assignment of benefits. We will do our best to calculate your available benefit amount. However, regardless of what your insurance plan pays, you are responsible for all fees. Patient portion is due in advance of treatment.

Authorization and Assignment of Benefits:
I understand my information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with informed consent. I authorize assignment of benefits to Edward W. Weakley, DDS.

Signature: ___________________Date:____________

Medical History

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain ____

Are you taking any prescriptions / over the counter drugs? Yes No

If yes, please explain ____

____

Do you use tobacco in any form? Yes No

Have you or do you take Redux/Fen Phen or Pondimin? Yes No

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

For women: Are you taking birth control pills? Yes No
Are you pregnant? Yes, week # ______ No
Are you nursing? Yes No

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

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV + AIDS
Y	N	Arthritis	Y	N	Hospitalized Any Reason
Y	N	Artificial Bone/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Latex Allergy
Y	N	Blood Transfusions	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Nervous / Anxious
Y	N	Diabetes	Y	N	Osteoporosis
Y	N	Difficulty Breathing	Y	N	Pacemaker
Y	N	Emphysema	Y	N	Psychiatric Problems
Y	N	Epilepsy	Y	N	Radiation Treatment
Y	N	Fainting Spells	Y	N	Rheumatic/Scarlet Fever
Y	N	Frequent Headaches	Y	N	Seizures
Y	N	Glaucoma	Y	N	Shingles
Y	N	Hay Fever	Y	N	Sickle Cell Disease
Y	N	Heart Attack	Y	N	Sinus Problems
Y	N	Heart Murmur	Y	N	Stroke
Y	N	Heart Surgery	Y	N	Thyroid Problems
Y	N	Hemophilia	Y	N	Tuberculosis
Y	N	Hepatitis	Y	N	Ulcers
			Y	N	Venereal Disease

Please list any other serious medical conditions that you have ever had:

____

____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

What is the most important thing we can do for you during your visit today: ____

Why did you leave your previous dentist? __________________

____

How would you describe the condition of your teeth and gums?

Good Fair Poor

Are you currently in any pain or discomfort with your teeth or gums? Yes No If yes, please explain: _________________

How often do you brush your teeth?_________ Floss?__________

Do your gums bleed when you brush? Yes No

Do your gums bleed when you floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: ____

Do you grind or clench your teeth? Yes No

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

If I could make a change to my smile, I would:

Make them whiter
Make them straighter
Close spaces
Replace black fillings
Repair chipped teeth
Replace missing teeth
Replace old crowns that don't match
Have a smile makeover

Do you have or have you had any of the following?

Braces
Dentures
Partials
Peridontal (gum) treatment

Signature: _________________________________Date:_____________