



M. Keith Ellis, D.D.S. • Michael Mefford, D.M.D.

2806 West Market Street • Johnson City, TN 37604
(423) 434-1370 • www.enhanceyoursmile.net

We are pleased that you have chosen our office for your dental needs. We will make every effort to provide you with the highest quality of dental care in a relaxed setting. We would like to ask your cooperation in completing the necessary forms to establish your record in our office. At your first visit we will perform a comprehensive examination and explain all pertinent findings and treatment possibilities. Please feel free to ask any questions you may have. Good communication is one of the keys to successful treatment.

Patient Information

Date _____

Soc. Sec. # _____

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Home Phone _____ Cell _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____ Cell _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____ Cell _____

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Birthdate _____ Soc. Sec.# _____

Work Phone _____

For Your Convenience, we offer the following methods of payment. Please check the option that you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card: Visa MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Sec.# _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Co. _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Sec.# _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Co. _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over, Please

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

- Are you under a physician's care now? Yes No N/A _____
- Have you ever been hospitalized or had a major operation? Yes No N/A _____
- Have you ever had a serious head or neck injury? Yes No N/A _____
- Are you taking any medications, pills, or drugs? Yes No N/A _____
- Do you take, or have taken, PHen-Fen or Redux? Yes No N/A _____
- Do you use tobacco? Yes No N/A _____
- Are you on a special diet? Yes No N/A _____
- Do you use controlled substances? Yes No N/A _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

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

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No N/A _____

Comments: _____

Reason for today's visit _____

Former dentist _____ City/State _____

Date of last dental visit _____ Last x-rays _____

General

How often do you brush? _____ Ever had Periodontic treatment? _____

How often do you floss? _____ Ever had Oral surgery? _____

Have you ever had Oral Cancer? _____

History

Any Hot or Cold Sensitivity? _____

Any Biting or Chewing Sensitivity? _____

Sensitivity to Sweets? _____

Ever had Orthodontic Treatment? _____

Ever wear a bite plate or night guard? _____

Behavior/Habits

Do you grind your teeth? _____

Do you bite the inside of your cheek? _____

Do you smoke? _____

Do you Bite your nails? _____

Do you use smokeless tobacco? _____

Cosmetic Concerns

Do you like the appearance of your teeth, your smile? If not, explain. _____

Do you have spaces that you do not like? If so, explain. _____

Do you like the color of your teeth? If not, explain. _____

What would you like to change the most in the appearance of your teeth? _____