MIDDLE TENNESSEE
PROSTHODONTICS

Bryan McLaughlin, DMD, MPH, FACP
Nicholas Miller, DMD, MS, FACP
Nisha Patel, DMD, MS, FACP
Stephen Peterman, DDS, FACP

PATIENT REGISTRATION

Patient's Name _____ Sex: M F Birth Date _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Please circle one: Single Married Divorced Widowed Home Phone _____

Employer _____ How long _____ Work Phone _____ SS# _____

Cell phone _____ E-mail _____

What is the best way to confirm your appointments: ☐ Phone ☐ E-mail

Spouse's Name (Parent if _____

Spouse's Birth Date _____ Spouse's SS# _____

Who may we thank for referring you? _____

Emergency contact – name, address and telephone number of a relative not living with you:

_____

DENTAL INSURANCE INFORMATION (Primary carrier)

Insured's Name _____ Insured's Birth Date _____ Insured's SS# _____

Insured's Employer _____

Insurance Company _____ Group# _____ Insurance Company Phone _____

DENTAL HISTORY

How long since you have seen a dentist? _____

Last complete dental exam date: _____

Last full mouth x- ray date: _____

Are you having problems now? Y N What? _____

Are you APPREHENSIVE about dental treatment? Y N

Have you had PERIODONTAL (gum) treatments? Y N

Do your gums BLEED or feel TENDER or IRRITATED? Y N

Are your teeth SENSITIVE to hot, cold, sweets or pressure? Y N

Are you UNHAPPY with the APPEARANCE of your teeth? Y N

Are you aware of GRINDING or CLENCHING your teeth? Y N

Do you have HEADACHES, EARACHES, or NECK PAIN? Y N

Do you have LOOSE or SHIFTING teeth? Y N

Previous Dentist _____ City _____ State _____ Phone _____

Patient Signature _____ Date _____

The above signed hereby authorizes Drs McLaughlin, Miller, Patel, and Peterman to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate. I also authorize Drs McLaughlin, Miller, Patel, and Peterman to perform any and all forms of treatment, medication and therapy. I also understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time service is rendered unless financial arrangements have been made. I also assign all insurance benefits to the doctor. In the event the balance of this account is turned over for collection the above signed will be responsible for collection cost and reasonable attorney's fees.