PREMIER
DENTAL GROUP OF KNOXVILLE
A Lifetime of Smiles

303 South Concord Street Suite 303
Knoxville TN 37919

Phone: 865-637-5708
Fax. 865-637-5712

Patient Personal History

Preferred Name: _____ Date: _____

Name: _____
Last First Middle Initial

Social Security Number: _____ Driver's License Number & State: _____

Home Phone #: _____ Cell Phone #: _____ Email Address: _____

Home Address: _____
City State Zip

Date of Birth: ___/___/___ Age: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ O

Your Employer: _____ How Long? _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Spouse's Name: _____ Names of Children: _____

Spouse's Employer: _____ Occupation: _____

INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No

Name of Policyholder: _____

Policyholder's Employer: _____

Policyholder's Date of Birth: ___/___/___

Name of Insurance Company: _____

Policyholder's SSN: _____

Business Phone #: _____

Relationship to Policyholder: Spouse Child Other: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient, friend? _____

Another patient, relative: _____ Dental Office: _____

☐ Yellow Pages ☐ Mailer ☐ Website ☐ Magazine ☐ Other: _____

DENTAL HEALTH QUESTIONNAIRE

Correct answers to the following questions will allow Dr. Kussman to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Reason for your visit: _____

☐ Yes ☐ No Are you having discomfort at this time?

☐ Yes ☐ No Have you ever had any serious trouble associated with previous dental treatment?

if so, please explain: _____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

☐ Yes ☐ No Are you interested in using Nitrous Oxide (laughing gas) for dental treatment?

Date of last visit: _____

☐ Yes ☐ No Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?

If so, when? _____

How often do you brush? _____

Brush is: ☐ Soft ☐ Medium ☐ Hard

☐ Yes ☐ No Are you interested in whitening your teeth?

Check one: Do you prefer ☐ Whitening Trays or ☐ the in-off ice Whitening Zoom?

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

MOUTH

☐ Yes ☐ No Bleeding, sore gums
☐ Yes ☐ No Unpleasant taste/bad breath
☐ Yes ☐ No Burning tongue/lips
☐ Yes ☐ No Frequent blisters, lips/mouth
☐ Yes ☐ No Swelling/lumps in mouth
☐ Yes ☐ No Ortho treatments (braces)
☐ Yes ☐ No Biting cheeks/lips
☐ Yes ☐ No Clicking/popping jaw
☐ Yes ☐ No Difficulty opening or closing jaw
☐ Yes ☐ No Gag easily

TEETH

☐ Yes ☐ No Oral Cancer
☐ Yes ☐ No Sensitive to hot, cold, sweets
☐ Yes ☐ No Sensitive to biting
☐ Yes ☐ No Food impaction
☐ Yes ☐ No Clenching/grinding
If so, when? _____
☐ Yes ☐ No Shifting in bite
☐ Yes ☐ No Change in bite
Other _____

MEDICAL HISTORY

☐ Yes ☐ No Are you now under the care of a physician?
If so, what is the condition of being treated? _____
The name and address of my physician is _____

☐ Yes ☐ No Have you had any serious illness within the past five (5) years?
If so, what was the illness? _____

☐ Yes ☐ No Have you been hospitalized or had an operation within the past five (5) years?
If so, what was the problem? _____

Have you had any of the following? Please check those that apply:

- ☐ Rheumatic fever, Rheumatic heart disease
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Congenital heart disease
- ☐ Cardiovascular disease (heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)
- ☐ Artificial or replacement valves
- ☐ Pacemaker
- ☐ Allergy or Sinus trouble
- ☐ Asthma
- ☐ Hay fever
- ☐ Hives or skin rash
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Diabetes
- ☐ Nervous or Mental disorders
- ☐ Psychiatric care
- ☐ Hepatitis
- ☐ Jaundice, or liver disease
- ☐ A.I.D.S., H.I.V. or other immunosuppressive disorder
- ☐ Arthritis or inflammatory rheumatism
- ☐ Arthritis or replacement joints, Prosthetic
- ☐ Digestive system - ulcers or stomach disorders
- ☐ Kidney trouble
- ☐ Tuberculosis
- ☐ Thyroid disorder
- ☐ Anemia or any blood disorder
- ☐ Other _____

☐ Yes ☐ No Have you ever been told you require antibiotic premedication before a dental procedure?
☐ Yes ☐ No Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma?
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Have you ever required a blood transfusion?
If so, please explain the circumstances and when? _____
☐ Yes ☐ No Are you taking any medications at this time?
Is so, what? _____

Are you allergic or have you reacted adversely to:

- ☐ Yes ☐ No Local anesthetics
- ☐ Yes ☐ No Penicillin
- ☐ Yes ☐ No Sulfa drugs
- Yes No Any antibiotics
- ☐ Yes ☐ No Fluoride
- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Iodine
- ☐ Yes ☐ No Codeine
- ☐ Yes ☐ No Narcotics
- ☐ Yes ☐ No Other _____

☐ Yes ☐ No Do you use any tobacco products?
☐ Yes ☐ No Do you have any disease, condition, or problem not listed above that you think I should know about?
If so, please explain: _____
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Are you nursing?
☐ Yes ☐ No Are you taking birth control or hormone therapy?

In case of emergency, please contact: Name: _____ Phone: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my medications, I will inform the dentist at the next appointment. In consideration of the medical services rendered and/or to be rendered, I/we agrees to pay Premier Dental Group regular charges for said services. I/we understand that I/we are responsible for all charges not paid by insurance. I/we further agree to pay any court costs and reasonable attorney's fees in the event that this account has to be referred to an attorney for collection. I/we understand that there will be a $55 cancellation fee for any appointment canceled or rescheduled within 24 hours. I/we have read the above or have had it explained to me/us and agree to all of its terms and as evidence of this fact sign my/our name below.

_____ Date: ____/____/_____ Relationship to Patient: _____
Signature *of* patient parent or *guardian*

_____ Date: ____/____/_____ Relationship to Patient: _____
Signature *of* guarantor *of* payment / responsible party

_____
Signature *of Dentist* Date