PREMIER
DENTAL GROUP OF KNOXVILLE
A Lifetime of Smiles

$50.00 cancellation fee for less than 24hrs notice of appointment

303 South Concord St., Ste. 323 Knoxville, TN 37919
(865) 637-5708 || info@pdgknoxville.com

Patient Personal History

Preferred Name _____ Date _____

Name _____
Last First Middle Initial

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

Date of Birth _____ Age _____ Sex ☐ M ☐ F Martial Status ☐ Single ☐ Married ☐ Child

Home Phone _____ Cell Phone _____ Email _____

May we contact you by text and/or email? ☐

Home Address _____
Street City State Zip

Parent info if patient is a minor: Date of Birth _____ Age _____ Sex ☐ M ☐ F Martial Status ☐ Single ☐ Married ☐ Child

Your Employer _____ Occupation _____

Business Address _____ Business Phone _____

Spouse's Name _____

Primary Dental Insurance

Do you have dental insurance? ☐ Yes ☐ No

Relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ other

Name of policyholder _____ Medical Insurance? ☐ Yes ☐ No Do you have? ☐ Medicaid ☐ Medicare

Policyholder's employer _____ Insurance Company Name _____

Policyholder's date of birth _____ Policyholder's SSN or ID# _____

Secondary Dental Insurance

Relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ other Policyholder's date of birth _____

Name of policyholder _____ Insurance Company Name _____

Policyholder's employer _____ Policyholder's SSN or ID# _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Patient _____

☐ Dental Office ☐ Promotional ☐ Google ☐ insurance ☐ Other _____

Dental Health Questionnaire

Correct asnwers to the following questions will allow PDG to treat you on a more individual basis, providing the care appropriate for your particular needs. ***Check yes or no 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
Are you interested in using Nitrous Oxide *(laughing gas)* for dental treatment? ☐ Yes ☐ No

☐ Yes ☐ No Have you ever been treated for periodontal disease *(gum disease, pyorrhea, trench mouth)*?
If so, when? _____

☐ Yes ☐ No How often do you brush? _____ Brush is ☐ Soft ☐ Medium ☐ Hard

☐ Yes ☐ No Are you interested in whitening your teeth? Do you prefer*(check one)* ☐ Whitening Trays *-or-* ☐ in-office Whitening?

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

MOUTH

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

TEETH

Oral Cancer	☐ Yes	☐ No
Sensitive to hot, cold, sweets	☐ Yes	☐ No
Sensitive to biting	☐ Yes	☐ No
Food impaction	☐ Yes	☐ No
Clenching/grinding	☐ Yes	☐ No

if so, when? _____

Medical History

Patient Name _____ Today's Date _____

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	If yes, please explain	_____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain	_____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain	_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes, please explain	_____
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Local Anesthetics ☐ Flouride ☐ Acrylic ☐ Metal ☐ Latex ☐ Antibiotics: _____

☐ Other If yes, please explain _____

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

AIDS/HIV Positive	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Miral Valve Protapse	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Osteoprorsis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Hepatitis A _____?	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

Emergency 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 or medical history, I will inform the staff at/before my scheduled appointment. I/we understand that I/we are responsible for all charges not paid by insurance. I/we further agree to pay any costs and reasonable attorney's fees in the event that this account has to be referred to an attorney for collection.

_____ Date _____ Relationship to Patient _____

Signature of patient *(parent or guardian if patient is a minor)*

_____

Signature of Dentist