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Patient Personal History Preferred Name: _____ Date: _____

Name: _____

Last First Middle Initial

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

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

Home Address: _____

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

How did you hear about our office? _____

Name if they are a patient? _____

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?

Circle one: Do you prefer Whitening Trays or the in-office 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:**

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

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?
If so, what? _____

Are you allergic or have you reacted adversely to:

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Local anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No Narcotics |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex |
- 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 Tammy J. Kussman D.D.S. her 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 cancelled 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.

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

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

Signature of Dentist Date