



Patient Personal History

Preferred Name: _____ Date: _____

Name: _____
Last First Middle Initial

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

Home Address: _____
City State Zip

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? _____

Have you ever been diagnosed with Sleep Apnea? Yes No

Please list your current medications: _____

Preferred Pharmacy: _____

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