



783 Old Hickory Blvd., Suite 305
Brentwood, Tennessee 37027

Phone: 615-346-3007
Fax: 615.346-3005
www.DrKussman.com

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:

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: Name of Insurance Company:
Policyholder's Employer: Policyholder's SSN:
Policyholder's Date of Birth: / / 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:
Are you having discomfort at this time?
Have you ever had any serious trouble associated with previous dental treatment?
Does dental treatment make you nervous?
Are you interested in using Nitrous Oxide (laughing gas) for dental treatment?
Date of last visit:
Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?
How often do you brush?
Brush is: Soft Medium Hard
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:

- | | | |
|---|---|---|
| <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?
Is 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 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.

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