TAMMY KUSSMAN DDS

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:**

- ☐ 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? _____

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:

☐ 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 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.

_____ 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