



**Patient Information Sheet**  
 6555 Chapman Hwy.  
 Knoxville, TN 37920  
**(865) 577-7535**

Date:
Review:
Cell Phone:

Patient's Name (Last, First, MI)		Number & Street-Address City, State, Zip	
Home Phone		Business Phone	
Date of Birth	Sex	Height	Weight
Occupation		Status	
Spouse Name (Last, First, MI)		Date of Birth	
Closest Relative (Not Living With You)		Phone Name	Relation
Referred By:			
May we contact you by Email? Yes    No		Email Address:	
<b>PLEASE ANSWER EACH QUESTION — PATIENT'S HEALTH HISTORY</b>			<b>Yes    No</b>
1. Have you been a patient in a hospital during the past 2 years?			
2. Have you been under the care of a physician during the past 2 years?			
3. Have you taken any kind of medicine or drugs during the past year?			
4. Are you taking any kind of medication now?			
5. Are you allergic to penicillin or any other drugs or medicine?			
6. Have you ever had any excessive bleeding requiring special treatment?			
7. Have you ever taken a prescription drug such as Phen-Fen?			
8. Have you ever been tested for Metal allergy in any form?			
<b>9. Have you had any of the following? (Check all that apply)</b>			
<input type="checkbox"/>	rheumatic fever	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	heart murmur	<input type="checkbox"/>	arthritis
<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	diabetes
<input type="checkbox"/>	cardiac pacemaker	<input type="checkbox"/>	jaundice
<input type="checkbox"/>	sinus trouble	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>		<input type="checkbox"/>	anemia
<input type="checkbox"/>		<input type="checkbox"/>	cancer
<input type="checkbox"/>		<input type="checkbox"/>	asthma
<input type="checkbox"/>		<input type="checkbox"/>	stroke
<input type="checkbox"/>		<input type="checkbox"/>	epilepsy
<input type="checkbox"/>		<input type="checkbox"/>	congenital heart lesions
<input type="checkbox"/>		<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>		<input type="checkbox"/>	artificial heart valves
<input type="checkbox"/>		<input type="checkbox"/>	psychiatric treatment
<input type="checkbox"/>		<input type="checkbox"/>	radiation therapy
<input type="checkbox"/>		<input type="checkbox"/>	HIV positive
<input type="checkbox"/>		<input type="checkbox"/>	AIDS
<input type="checkbox"/>		<input type="checkbox"/>	joint implant
<input type="checkbox"/>		<input type="checkbox"/>	valve implant
<input type="checkbox"/>		<input type="checkbox"/>	chemotherapy
		<b>Yes    No</b>	
10. (Women) Are you pregnant?			Are you nursing?
11. Do you have any other serious illnesses?			Explain:
12. Do you have other medical situations or limitations?			Explain:
<b>PHYSICIANS</b>			
Name		Phone	
Name		Phone	
<b>Chief Dental Complaint:</b>			
<b>What, if anything, would you like to change about your smile?</b>			
<b>Employment:</b>	Business	Address	Social Security #
Patient:			
Spouse			
<b>1<sup>st</sup> DENTAL INSURANCE</b>		<b>2<sup>nd</sup> DENTAL INSURANCE</b>	
EMPLOYEE NAME		EMPLOYEE NAME	
DATE OF BIRTH		DATE OF BIRTH	
INSURANCE CO. NAME		INSURANCE CO. NAME	
ADDRESS		ADDRESS	
TELEPHONE		TELEPHONE	
PROGRAM OR POLICY #		PROGRAM OR POLICY #	
UNION LOCAL OR GROUP		UNION LOCAL OR GROUP	
Financial responsibility:			

I hereby authorize Dr. Robert C. Freeman to release any and all medical (including dental information to the above-named insurance carriers (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I understand I am financially responsible to Dr. Robert C. Freeman for charges not paid by Insurance. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required. If you have insurance; we will gladly process your forms, however we must receive payment for your portion at the time of services.

PATIENT'S SIGNATURE/GUARDIAN

Date