Date _____ Reviewed: _____

ROBERT C. FREEMAN, D.D.S.
6555 Chapman Highway
Knoxville, Tennessee 37920
Phone 577-7535

Child's Name _____
Last First Middle Number & Street-Address

_____
City State Zip Code Home Phone Business Phone

Date of Birth _____ Sex _____ Height _____ Weight _____ School _____

Mother: _____
Name Address Phone

Father: _____
Name Address Phone

Closest relative not living with you _____ Phone _____

If you are completing this form for another person, what is your relationship? _____

Referred by: _____

PLEASE ANSWER EACH QUESTION — PATIENT'S HEALTH HISTORY CIRCLE

1. Have you been a patient in a hospital during the past 2 years? . . . . . YES NO
2. Have you been under the care of a physician during the past 2 years? . . . . . YES NO
3. Have you taken any kind of medicine or drugs during the past year? . . . . . YES NO
4. Are you taking any kind of medication now? . . . . . YES NO
   If so what _____
5. Are you allergic to penicillin or any drugs or medicine? . . . . . YES NO
   Drug allergies _____
6. Have you ever had any excessive bleeding requiring special treatment? . . . . . YES NO
7. Circle any of the following which you have had:

rheumatic fever	tuberculosis	anemia	congenital heart lesions	HIV pos.
heart murmur	arthritis	cancer	high blood pressure	AIDS
heart trouble	diabetes	asthma	artificial heart valves	joint implant
cardiac pacemaker	jaundice	stroke	psychiatric treatment	valve inplant
sinus trouble	hepatitis	epilepsy	radiation therapy	chemotherapy

8. (Women) Are you pregnant? . . . . . YES NO Are you nursing? . . . . . YES NO
9. Have you had any other serious illnesses? . . . . . YES NO

SIGNATURE: _____ DATE: _____

PARENT'S SIGNATURE: _____ DATE: _____
(GUARDIAN)

PHYSICIANS _____
Name Phone

_____
Name Phone

CHIEF DENTAL COMPLAINT: _____

_____

Employment

Mother _____
Business Address Social Security #

Father _____
Business Address Social Security #

DENTAL INSURANCE — 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

DENTAL INSURANCE — 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

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.

PATIENT'S SIGNATURE _____ Date _____

PARENT'S SIGNATURE _____ Date _____
(GUARDIAN)