DR. ROBERT C. Freeman
COSMETIC & GENERAL DENTISTRY
6555 Chapman Hwy.
Knoxville, TN 37920
(865) 577-7535

Date _____

Review: _____

_____

_____

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

_____
City State Zip Code Home Phone Business Phone

Date of Birth _____ Sex _____ Height _____ Weight _____ Occupation _____

Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

Spouse Name _____
Last First Middle Date of Birth

Closest relative not living with you _____ Phone _____
Name Relation

Referred by: _____

Would you like us to contact you by E-Mail? _____ _____ _____
Yes No E-Mail Address

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 other drugs or medicine? ..... YES NO

   Drug allergies

6. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
7. Have you ever taken a prescription drug such as Phen-Fen? ..... YES NO
8. Have you ever been tested for Metal allergy in any form? ..... YES NO
9. 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 implant
sinus trouble	hepatitis	epilepsy	radiation therapy	chemotherapy

10. (Women) Are you pregnant? ..... YES NO Are you nursing? ..... YES NO
11. Do you have any other serious illnesses? ..... YES NO
12. Do you have other medical situations or limitations? ..... YES NO

SIGNATURE: _____ DATE: _____

PHYSICIANS _____
Name Phone

_____
Name Phone

CHIEF DENTAL COMPLAINT: _____

_____

WHAT, IF ANYTHING, WOULD YOU LIKE TO CHANGE ABOUT YOUR SMILE? _____

_____

_____

Employment

Patient _____
Business Address Social Security #

Spouse _____
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. **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 _____ Date _____
(GUARDIAN)

_____

_____

_____

_____