HARRY M. SUEKERT, DDS, PLLC (423) 698-8651
Family and Cosmetic Dentistry 3500 Ringgold Rd. · Chattanooga, TN 37412

Thank You for Selecting Our Dental Team

To help us meet all of your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Date ____________________
Name ____________________ Cell Phone ____________________
Soc. Sec.# ____________________ Home Phone ____________________
Address ____________________ City ________ State ________ Zip ____________
E-Mail Address ____________________ Birthdate ____________________
Check Appropriate Box: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed
If Student, Name of School/College ____________ City ________ State ________ ❑ Full Time ❑ Part Time
Patient's Employer ____________________ Work Phone ____________________
Business Address ____________________ City ________ State ________ Zip ____________
Spouse Name ____________ Employer ____________ Work Phone ____________________
Whom may we thank for referring you? ____________________
Person to contact in case of emergency? ____________________ Phone ____________________

Responsible Party

Name of Person Responsible for the Account ____________________ Relationship to Patient ____________
Address ____________________ Home Phone ____________________
E-mail ____________________ Cell Phone ____________________
Driver's License # ____________ Birthdate ____________ Financial Institution ____________
Employer ____________ Work Phone ____________ SS# ____________________
Is this person currently a patient in our office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. ❑ Cash ❑ Personal Check ❑ VISA ❑ MasterCard ❑ Care Credit ❑ Discover

Insurance Information

Name of Insured ____________________ Relationship to Patient ____________
Soc. Sec.# ____________ Birthdate ____________ Home Phone ____________________
Name of Employer ____________ Union or Local # ________ Work Phone ____________________
Employer Address ____________ City ____________ State ________ Zip ____________
Insurance Co. ____________ Group # ____________ Policy ID # ____________________
Ins. Co. Address ____________ City ____________ State ________ Zip ____________

Do you have any additional insurance? ❑ Yes ❑ No If yes, complete the following.

Name of Insured ____________________ Relationship to Patient ____________
Soc. Sec.# ____________ Birthdate ____________ Home Phone ____________________
Name of Employer ____________ Union or Local # ________ Work Phone ____________________
Employer Address ____________ City ____________ State ________ Zip ____________
Insurance Co. ____________ Group # ____________ Policy ID # ____________________
Ins. Co. Address ____________ City ____________ State ________ Zip ____________

Dental Information

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Do your gums bleed when you brush?	❑	❑	❑	Have you ever had orthodontic (braces) treatment?
❑	❑	❑	Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑	Do you have headaches, earaches or neck pains?
❑	❑	❑	Have you had any periodontal (gum) treatments?	❑	❑	❑	Do you wear removable dental appliances?

❑ ❑ ❑ Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain______________________

How would you describe your current dental problem? ______________________

Date of last dental visit______________ Previous Dentist______________________ Date of last dental x-rays ______________

What was done at that time? ______________________

How do you feel about the appearance of your teeth?______________________

How do you feel about comprehensive dental treatment?______________________

Medical Information

Yes	No	Don't Know	
❑	❑	❑	Are you in good health?
❑	❑	❑	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems?

Yes	No	Don't Know	
❑	❑	❑	Active Tuberculosis
❑	❑	❑	Persistent cough greater than a 3 week duration
❑	❑	❑	Cough that produces blood
❑	❑	❑	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? ______________
			Physician ______________________ (Name / Phone / Address / City/State/Zip)
❑	❑	❑	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? ______________
❑	❑	❑	Are you taking or have recently taken any medication(s) including non-prescription medicine? If so, what medicine(s) are you Taking?__________
			Prescribed ______________________
			Over the counter______________________
			Natural or herbal preparations______________________
❑	❑	❑	Are you taking, or have taken, any diet drugs such as Pondimin (Fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?
❑	❑	❑	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ______________ In the past month? __________
			If yes, ___________# of drinks per day for ___________# of years
❑	❑	❑	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ❑ Yes ❑ No
			Frequency of use (daily, weekly, etc.)______________ Number of years of recreational drug use ______________
❑	❑	❑	Do you use tobacco (Smoking, snuff, Chew)? If so, how interested are you in stopping? (Check one) ❑Very ❑ Somewhat ❑ Not Interested
❑	❑	❑	Do you wear contact lenses?

Allergies - Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Local anesthetics	❑	❑	❑	Latex
❑	❑	❑	Aspirin	❑	❑	❑	Iodine
❑	❑	❑	Penicillin or other antibiotics	❑	❑	❑	Hay fever/seasonal
❑	❑	❑	Barbiturates, Sedatives, or sleeping pills	❑	❑	❑	Animals
❑	❑	❑	Sulfa drugs	❑	❑	❑	Food (Specify) ______________
❑	❑	❑	Codeine or other narcotics	❑	❑	❑	Other (Specify)______________

To yes responses, specify type of reaction ______________________

Yes	No	Don't Know	
❑	❑	❑	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this done?_______________
❑	❑	❑	Have you had any complications or difficulties with your prosthetic joint?
❑	❑	❑	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?
			Name of physician or dentist_______________ Phone _______________

Do you have or have you had any of the following?

Yes	No	Don't Know	
❑	❑	❑	Abnormal bleeding
❑	❑	❑	AIDS or HIV infection
❑	❑	❑	Anemia
❑	❑	❑	Arthritis
❑	❑	❑	Rheumatoid arthritis
❑	❑	❑	Asthma
❑	❑	❑	Blood transfusion If yes, date ___________
❑	❑	❑	Cancer/chemotherapy/radiation treatment
❑	❑	❑	Cardiovascular disease. If yes, specify below: ○ Angina ○ Arteriosclerosis ○ Artificial heart valves ○ Coronary insufficiency ○ Coronary occlusion ○ Damaged heart valves ○ Heart attack ○ Heart murmur ○ Inborn heart defects ○ Mitral valve prolapse ○ Pacemaker ○ Rheumatic heart disease
❑	❑	❑	Chest pain upon exertion
❑	❑	❑	Chronic pain
❑	❑	❑	Persistent diarrhea

Yes	No	Don't Know	
❑	❑	❑	Disease, drug, or radiation induced immunosurpression
❑	❑	❑	Diabetes. If yes, specify below: ○ Type I (insulin dependent) ○ Type II
❑	❑	❑	Dry mouth
❑	❑	❑	Eating disorder. If yes, specify ___________
❑	❑	❑	Epilepsy
❑	❑	❑	Fainting spells or seizures
❑	❑	❑	G.E. reflux
❑	❑	❑	Glaucoma
❑	❑	❑	Hemophilia
❑	❑	❑	Hepatitis, jaundice or liver disease
❑	❑	❑	Recurrent infections Indicate type of infection _______________
❑	❑	❑	Kidney problems
❑	❑	❑	Low blood pressure
❑	❑	❑	High blood pressure
❑	❑	❑	Mental helath disorders If yes, specify below: _______________ _______________
❑	❑	❑	Malnutrition
❑	❑	❑	Migraines
❑	❑	❑	Night sweats

Yes	No	Don't Know	
❑	❑	❑	Neuroligical disorders If yes, specify ___________
❑	❑	❑	Osteoporosis
❑	❑	❑	Persistent swollen glands in neck:
❑	❑	❑	Respiratory problems. If yes, specify below: ○ Emphysema, ○ Bronchitis, etc.
❑	❑	❑	Severe headaches
❑	❑	❑	Severe or rapid weight loss
❑	❑	❑	Sexually transmitted disease
❑	❑	❑	Sinus trouble
❑	❑	❑	Sleep disorder
❑	❑	❑	Sores or ulcers in the mouth
❑	❑	❑	Stroke
❑	❑	❑	Systemic lupus erythematosus
❑	❑	❑	Thyroid problems
❑	❑	❑	Tuberculosis
❑	❑	❑	Ulcers
❑	❑	❑	Excessive urination
❑	❑	❑	Do you have any disease, condition, or problem not listed above that you think I should know about? _______________ _______________ _______________

Women Only

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Abnornal bleeding	❑	❑	❑	Nursing
❑	❑	❑	Taking Birth Control Pills	❑	❑	❑	Pregnant

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of Harry M. Suekert, DDS, PLLC of any changes in my medical status. I also authorize the dental staff to perform routine diagnostic and preventive services including, but not limited to examination, study models, photographs, simple cleaning, x-rays, fluoride treatment and oral hygiene instruction. I also authorize Harry M. Suekert, DDS, PLLC to release any information including the diagnosis and the records of treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Harry M. Suekert, DDS, PLLC any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature of Patient_______________________________ Date_______________________

For Completion by Dentist

Comments on patient interview concerning health history ______________________________

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Significant findings from questionnaire or oral interview ______________________________

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Dental management considerations ______________________________

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Signature of Dentist______________________________ Date ______________

Health History Update: On a regular basis the patient should be questtioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist