Print Form

Keith N. Shrum Dentistry
3441 Lebanon Road-Suite 105, Hermitage, TN 37076
Phone: (615) 883-4600

Date:

Name: Date of Birth: SS#
Home Address (Street #/City/State/Zip):
Your Employer: Occupation:
Home Phone: Cell: Work: X
E-mail Address: Referred by:
Date of last dental visit: Purpose of this visit:
Person responsible for paying account:
Address & phone number of that person if different than above:

INSURANCE INFORMATION:

1)Do you have dental insurance? YES☐ NO☐ (IF NO, SKIP TO MEDICAL HISTORY SECTION)
2)Is this coverage through your employer? YES☐ NO☐ (IF NO, SKIP TO QUESTION 5)
3)Dental insurance company: GROUP # ID#
4)Do You Have Other Dental Insurance Coverage? Yes☐ No☐(If No, Skip to MEDICAL HISTORY Section)
5) This coverage is through: SPOUSE☐ PARENT☐ OTHER☐
Their name: Their SS#
Their date of birth: Employers name:
Insurance Co. Phone # Group # ID#

MEDICAL HISTORY:

Do you have a personal physician? YES☐ NO☐
Their name: Their phone #: Date Of Last Visit:
Are you currently under a physician's care? YES☐ NO☐
If yes, please explain:
Are you presently taking any medication? YES☐ NO☐
If yes, please list:
Do you smoke or use tobacco in any form? YES☐ NO☐
(WOMEN) Are you pregnant? YES☐ NO☐ (IF YES) Expecting when?
Are you allergic to any of the following drugs? (Please check correct response)

Y☐	N☐	PENICILLIN	Y☐	N☐	CODEINE
Y☐	N☐	ERYTHROMYCIN	Y☐	N☐	DENTAL ANESTHETICS

Are you allergic to any other drugs? YES☐ NO☐
If yes, please list:
Have you ever had any of the following medical conditions? (Please check the correct response)

Y☐	N☐	HEART MURMUR/RHEUMATIC FEVER	Y☐	N☐	CANCER/CHEMOTHERAPY
Y☐	N☐	HEART ATTACK/STROKE	Y☐	N☐	RADIATION TREATMENT
Y☐	N☐	HEART SURGERY	Y☐	N☐	HIV/AIDS
Y☐	N☐	CHRONIC HEPATITIS	Y☐	N☐	KIDNEY PROBLEMS
Y☐	N☐	ANEMIA	Y☐	N☐	SINUS PROBLEMS
Y☐	N☐	HIGH/LOW BLOOD PRESSURE	Y☐	N☐	RESPIRATORY PROBLEMS
Y☐	N☐	SEVERE HEADACHES	Y☐	N☐	PSYCHIATRIC PROBLEMS
Y☐	N☐	EPILEPSY/SEIZURES/FAINTING	Y☐	N☐	DIABETES
Y☐	N☐	DRUG/ALCOHOL ABUSE	Y☐	N☐	TUBERCULOSIS (TB)
Y☐	N☐	HEMOPHILIA/ABNORMAL BLEEDING	Y☐	N☐	ARTIFICIAL JOINTS
Y☐	N☐	MITRAL VALVE PROLAPSE	Y☐	N☐	ARTHRITIS
Y☐	N☐	ARTIFICIAL HEART VALVE	Y☐	N☐	ULCER

I certify that the information given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status. I agree to pay for all professional fees and treatment at the time of service, or my portion not covered by dental insurance, for myself or the above named patient, unless other financial arrangements are approved. I also agree to pay for all costs of collection, including attorney fees and court costs, should additional means of collection be required. In addition, my signature on this form is my acknowledged authorization for the Dr. to seek a Credit Report if credit is to be extended.

Print Form

Attention Mac users: to print this form please use the file/print function instead of the Print Form button.

Signature Date