SANDHILLS Family Dental

WELCOME

ABOUT YOU

Today's Date: _____

Patient Name: _____

What you prefer to be called: _____ ☐Male ☐Female

Birthdate: _____ Age: _____ SS#: _____

Address: _____

_____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email Address: _____

Communication Preference: ☐Phone Call ☐Email ☐Text

Employer: _____ How Long? _____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name: _____

How many children do you have (if any)? _____

ACCOUNT INFO *Person responsible for account.*

Name: _____ Relation: _____

Billing Address: _____

_____

SS#: _____ Driver's License #: _____

Phone #: _____

Insurance Info

Primary Dental Insurance

Co. Name: _____

Address: _____

_____

Phone #: _____

Member ID #: _____

Group #: _____

Payor ID: _____

insured's Name: _____

Relation: _____ D.O.B. _____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____

Phone #: _____

Member ID #: _____

Group #: _____

Payor ID: _____

insured's Name: _____

Relation: _____ D.O.B. _____

Insured's Employer: _____

EMERGENCY CONTACT

Whom should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Who is your Medical Doctor? _____ Doctor's Phone #: _____

Dental Information

Reason for Today's Visit: ☐Exam ☐ Emergency ☐ Consultation Are you in pain? _____ How Long? _____

Please mark any of the following problems:

☐ Discomfort, clicking, or popping in jaw
☐ Blisters/Sores in/around mouth
☐ Red, swollen, or bleeding gums
☐ Broken/chipped tooth
☐ Lost/Broken Fillings
☐ Teeth grinding
☐ Ringing in ears
☐ Stained teeth
☐ Locking Jaw
☐ Bad Breath
☐ Sensitive tooth, teeth, or gums
☐ Active Decay/Cavities
☐ Other: _____

Do you require pre-medication? ☐Yes ☐No ☐Unsure Have you been treated for gum disease? _____

Previous Dentist Name: _____ Previous Dentist Location: _____

Last Dental Exam: _____ Last Dental X-rays: _____ Last Dental Cleaning: _____

Have you had problems with previous dental treatment? If so, explain: _____

Times a day you brush: _____ Times a week you floss: _____ Type of tooth bristles: ☐Soft ☐Med ☐Hard

Rate your smile from 1-10: _____ Would you like whiter teeth? **Y N** Have you had orthodontics? **Y N**

Things you would change about your smile: _____

Medical History & Information

What medications are you taking? ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Stimulants ☐ Insulin

☐ Blood Thinners (type): _____ ☐ Tranquilizers ☐ Osteoporosis Meds ☐ Vitamins/Supplements

☐ Others (please list): _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax)? **Y N** Phen-fen/Redux? **Y N**

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart Murmur
Y N Lung Disease
Y N Liver Problems
Y N Blood Disease
Y N Kidney Problems
Y N Scarlet Fever
Y N Tuberculosis TB
Y N HIV+/AIDS/ARC
Y N Rheumatic Fever
Y N Sinus Problems
Y N Shingles
Y N Hepatitis
Y N Heart Attack/Stroke
Y N Thyroid Problems
Y N Seizures/Epilepsy
Y N Venereal Disease
Y N Cosmetic Surgery
Y N Dizziness/Fainting
Y N Cold/Fever Blisters
Y N Blood Transfusion
Y N Alcohol/Drug Abuse
Y N Eating Disorder
Y N Glaucoma
Y N Arthritis/Gout
Y N Heart Surg./Pacemaker
Y N Congenital Heart Defect
Y N Artificial Heart Valves
Y N Mitral Valve Prolapse
Y N G.I. Problems/Ulcers
Y N Emphysema/Asthma
Y N Diabetes/Hypoglycemia
Y N Psychiatric Problems
Y N Back/Neck Problems
Y N Respiratory Problems
Y N Leukemia
Y N Sleep Apnea
Y N Heart Disease/Angina
Y N Cancer/Tumor/Growth
Y N Chemotherapy/Radiation
Y N X-ray or Cobalt Treatment
Y N Frequent Thirst/Urination
Y N Bleeding Problems/Anemia
Y N High/Low Blood Pressure
Y N Artificial Bones/Joints/Implants
Y N Severe/Frequent Headaches
Y N Jaw Problems TMJ/TMD
Y N Allergies
Y N Nervousness

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐Tetracycline ☐ Aspirin ☐Codeine ☐ Dental Anesthetics ☐Foods ☐Others: _____

Do you use tobacco? **Y N** If so, how used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? **Y N**

For women: Are you taking birth control? **Y N** Are you taking hormone replacement? **Y N**

Are you pregnant? ☐Yes/How Long? _____☐ No Are you nursing? **Y N** How many children have you had? _____

I understand the above information & guarantee this form was completed correctly to the best of my knowledge & understand it is my responsibility to inform this office of any changes to the information I've provided. I also authorize the staff to perform any necessary services needed during diagnosis & treatment & authorize the provider to release any information required to process insurance claims. **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature: _____ **Date:** _____