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 #: _____

Medical History & Information

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

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

What medications are you taking? Please list all.

☐ Nerve Pills: _____

☐ Pain Killers: _____

☐ Muscle Relaxers: _____

☐ Stimulants: _____

☐ Insulin: _____

☐ Blood Thinners: _____

☐ Tranquilizers: _____

☐ Osteoporosis Meds: _____

(Bisphosphonates - injectable/oral)

☐ Vitamins/Supplements: _____

☐ Others (please list): _____ For: _____

_____ For: _____

_____ For: _____

_____ For: _____

_____ For: _____

_____ For: _____

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	☐Lost/Broken Fillings	☐Locking Jaw
☐Blisters/Sores in/around mouth	☐Teeth grinding	☐Bad Breath
☐Red, swollen, or bleeding gums	☐Ringing in ears	☐Sensitive tooth, teeth, or gums
☐Broken/chipped tooth	☐Stained teeth	☐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: _____

Miscellaneous

Any other important information, questions, comments, or concerns for our dentists, hygienists, & staff?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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:** _____