



91 Sams Point Road
Beaufort, SC 29907
(843) 525-6866

Patient Information:

Full Name: Nickname: Email
Address: City: State: Zip:
Phone: Home Cell Work
Sex: M / F Marital Status: Married / Single / Widow Date of Birth: S.S #:

Account Information: (please circle one) Self Spouse Parent Guardian Facility

Full Name: Nickname: Occupation:
Address: City: State: Zip:
Phone: Home Cell Work
Sex: M / F Marital Status: Married / Single / Widow Date of Birth: S.S #:

Dental Insurance Company: Employer:
Subscriber's Name: Date of Birth: S.S #:

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Dental Information

Reason for today's visit: Are you in pain? [] Yes [] No, For How Long?

Please indicate any of the following problems by checking off the corresponding box:

- [] Discomfort, clicking, or popping in jaw [] Lost / broken filling(s) [] Stained teeth [] Difficulty closing jaw
[] Red, swollen, or bleeding gums [] Teeth grinding / clenching [] Locking jaw [] Difficulty opening jaw
[] A removable dental appliance [] Ringing in ears [] Bad breath [] Loose / shifting teeth
[] Blisters / sores in or around the mouth [] Broken / chipped tooth [] Burning tongue / lips [] Food caught between teeth
[] Prolonged bleeding from an injury / extraction [] Gum Disease [] Toothache [] Swelling / lumps in mouth
[] Recent infections or sore throat [] Other:
[] Sensitivity in teeth

Medical History

Do you have or have you had any of the following? (check all that apply)

Do you have any known allergies?

Have you ever had a joint replacement?

Do you have a history of heart surgery, heart infection, or unrepaired heart defects?

Do you take any blood thinning medications?

Have you ever been treated with drugs for osteoporosis, cancer, or Paget's disease?

Are you pregnant or think you might be?

- Heart Problems
- Chest Pain
- Shortness of breath
- Blood pressure problems
- Heart murmur
- Rheumatic fever
- Pacemaker
- Artificial heart valve
- Easy bruising
- Frequent nosebleed/Abnormal bleeding
- Anemia
- Sinus problems
- Skin rashes
- Taking allergy medication
- Asthma
- Intestinal problems
- Ulcers
- Weight gain or loss
- Constipation/diarrhea
- Kidney or bladder problems
- Fainting spells, seizures or epilepsy
- Stroke(s)
- Frequent or severe headaches
- Thyroid problems
- Persistent cough or swollen glands
- Premedication required by physician

- Cancer/tumor
- Diabetes
- Urinate more than six times a day
- Thirsty or mouth is dry much of the time
- Family history of diabetes
- Tuberculosis or other respiratory diseases
- Do you use tobacco products?
If so, how much? _____
- Hepatitis, jaundice or liver trouble
- Herpes
- Sexually Transmitted Diseases
- HIV positive/AIDS
- Glaucoma
- Do you wear contact lenses?
- Head injury
- Epilepsy or other neurological disease
- History of alcohol or drug abuse

Are you currently taking any of the following medications?

- Antibiotics or Sulfa Drugs
- Anticoagulants (eg. Coumadin)
- High Blood Pressure Medicine
- Tranquilizers or Antidepressants
- Diabetes Medication
- Medication for heart problems
- Nitro glycerin
- Cortisone (Steroids)
- Cholesterol Medication
- Nonprescription drugs or supplements
- Other _____

Have you ever had a reaction to any of the following?

- Local anesthesia ("Novocaine")
- Penicillin or other antibiotics
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin, acetaminophen or ibuprofen
- Codeine, Demerol or other narcotics
- Metals
- Latex or rubber dam
- Other _____

Patient signature/legally authorized representative

Date _____

Printed name if signed on behalf of the patient

Relationship _____