DONOVAN
FAMILY DENTISTRY

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 #**: _____

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

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	_____		

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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_____

_____ *Date*_____
Patient signature/legally authorized representative

_____ *Relationship*_____
Printed name if signed on behalf of the patient