

Powdersville Dental Associates, P. A.
100 Commons Boulevard
Piedmont, SC 29673-7766
(864) 269-0820 Fax (864) 269-0377

Date: _____
Name: _____ Legal Name: _____
Address: _____

Phone -- Home: _____ Work: _____ Cell: _____
Email: _____ Driver's License Number: _____
Date of Birth: _____ Sex: M ___ F ___ Marital Status: S ___ M ___ D ___ W ___
SSN: _____ Full Time Student? ___ Where? _____
Occupation: _____ Employer: _____
Name of Spouse: _____ Occupation: _____ Employer: _____
Dental Insurance Company: _____ Policy Number: _____
Name of Person Insured: _____ Date of Birth of Insured: _____
Referred By: _____ Previous Dentist: _____
In Case of Emergency Contact: _____ Phone: _____
Person Responsible for Account: _____

MEDICAL:

	Yes	No
Have you had any major operations or serious illness?	___	___
If so, what? _____		
Are you currently under medical treatment?	___	___
Have you had any allergic reactions to any drugs or other items, (including penicillin, tetracycline, codeine, aspirin, and peanuts)?	___	___
Please specify: _____		
Have you had a blood transfusion in the last 5 years?	___	___
Have you ever had abnormal bleeding problems after a cut or tooth extraction?	___	___
Has your physician ever informed you that you need to take an antibiotic before a dental procedure?	___	___
Have you ever had heart surgery or a joint replacement?	___	___
Are you currently taking drugs or medications of any kind?	___	___
If so, what? _____		
Date of your last physical exam: _____		

Do you have any of the following:

	Yes	No		Yes	No
Heart Ailment	___	___	Hepatitis or Jaundice	___	___
High Blood Pressure	___	___	Liver Disease	___	___
Rheumatic Fever	___	___	Venereal Disease	___	___
Heart Murmur	___	___	HIV positive	___	___
Mitral Valve Prolapse	___	___	Stomach/GI Disease	___	___
Angina	___	___	Kidney Disease	___	___
Stroke	___	___	Tumors or Growths	___	___
Blood Disease	___	___	Diabetes	___	___
Hemophilia	___	___	Tuberculosis	___	___
Asthma	___	___	Epilepsy	___	___
Herpes	___	___	Psychiatric Treatment	___	___
Anemia	___	___	Arthritis	___	___
Cardiac Pacemaker	___	___	Lupus	___	___
Thyroid Disease	___	___	Do you Smoke?	___	___
Osteoporosis/Bone Disease	___	___			
Women: Are you pregnant?	___	___	If yes, due date _____		

DENTAL:

How long has it been since your last dental appointment? _____

What was done at that time? _____

How long has it been since your teeth were last cleaned? _____

Why did you leave your last dentist? _____

What is your main dental concern? _____

Are you happy with your smile? _____

Please indicate with an (X) any of the following that pertains to you:

- Teeth sensitive to cold, hot, sweets, or pressure
- Bleeding gums
- Food lodges between teeth when eating, esp. meats
- Clenching or grinding teeth
- Swelling or lumps in mouth
- Jaws ever pop or ache
- Frequent headaches
- Have removable appliance
- Swollen glands on neck
- Bad Breath
- Unpleasant taste
- Have worn braces
- Mouth breathing
- Snoring
- Receding gums
- Missing Teeth
- Wish to have whiter teeth
- Complications from previous dental treatment
- Unfavorable dental experience in past
- Other dental problems

Is there any thing else you feel we need to know before treatment?

To the best of my knowledge, I have accurately answered the questions on this form. I understand that inaccurately answering these questions can be dangerous to my (or my child's) health. It is my responsibility to inform this dental office of any changes in my (or my child's) health history. I authorize the dentist to release any information regarding my dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Powdersville Dental Associates, P.A. insurance benefits otherwise payable to me. I understand that my dental insurance company may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent if minor): _____