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: _______________________Pharmacy phone: ________________

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? Or are you taking any blood thinning medications?	___	___
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
___ Clinching 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): ____