Fort Mill (803) 548-2428 Rock Hill (803) 329-1540 Sumter (803) 775-5500

Patient Information

Patient's Name: _____ Nickname: _____
Date of Birth: _____ SSN: _____ Age: _____ Male: _____ Female: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail: _____
General Dentist: _____
Dentist Address: _____ Dentist Phone: _____
Who may we thank for referring you? _____
Other family members seen by us: _____

Primary Dental Insurance Company

Insurance Company : _____
Address: _____
Phone: _____
Group/Policy Number: _____
Insured Name: _____
Relationship to Patient: _____
Date of Birth: _____
Social Security #: _____

Secondary Dental Insurance Company

Insurance Company : _____
Address: _____
Phone: _____
Group/Policy Number: _____
Insured Name: _____
Relationship to Patient: _____
Date of Birth: _____
Social Security #: _____

If Patient Is A Minor

Responsible Party

Name: _____
Relation: _____ Do you have legal custody of the child? Yes____ No____

Mother's Information (if patient is a minor)

Name: _____
Date of Birth: _____
SSN: _____
Driver's License #: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Address: _____
How long at this address? _____
Employed by: _____
Occupation: _____

Father's Information (if patient is a minor)

Name: _____
Date of Birth: _____
SSN: _____
Driver's License #: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Address: _____
How long at this address? _____
Employed by: _____
Occupation: _____

What brings you to the orthodontist today?

_____

_____

_____

History

Y N Are you currently in pain?
Y N Do you experience any TMJ symptoms?
Y N Have you ever had any serious head or neck trauma?
Y N Any problems associated with dental work?
Y N Finger/thumb habit?
Y N Nail biting habit?
Y N Do you use tobacco products?
Y N Is your water fluoridated?
Y N Are you taking fluoride supplements?
Y N Has puberty begun?
Y N Are you pregnant? If so how many weeks? _____
Y N Are you nursing?
Y N Are you currently under the care of a physician?
Please explain: _____
Y N Are you currently under psychiatric care?
Please explain: _____
How many times a day do you brush? _____
How many times a day do you floss? _____
Please describe your current dental health: _____
_____
Patient's Physician: _____
Physician's Phone: _____

Medications

Y N Bisphosphonates drugs for osteoporosis
Y N Antibiotic prophylaxis before dental procedures
Y N Cortisones
List any additional medications you are currently taking:

_____
_____
_____
_____

Allergies

Are you allergic to any of the following?

Y N Acrylic
Y N Aspirin
Y N Codeine
Y N Copper
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Local Anesthetics
Y N Metal
Y N Penicillin
Y N Sulfa Drugs
Y N Tetracycline
Other: _____
_____
_____
_____

Medical History

Do you have, or have had, any of the following?

Y N HIV/AIDS
Y N Cold Sores/Fever Blister
Y N Herpes
Y N Venereal Disease
Y N Shingles
Y N Cancer
Y N Chemotherapy
Y N Radiation Treatments
Y N Asthma
Y N Hepatitis A, B, or C
Y N Liver Disease
Y N Yellow Jaundice
Y N Epilepsy or Seizures
Y N Fainting Spells/Dizziness
Y N Convulsions
Y N Frequent Headaches
Y N Sinus Problems
Y N Chest Pains
Y N Congenital Heart Disorder
Y N Heart Trouble/Disease
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Irregular Heartbeat
Y N Artificial Heart Valve
Y N Stroke
Y N High Cholesterol
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Hay Fever
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Anaphylaxis
Y N Hives or Rash
Y N Parathyroid Disease
Y N Osteoporosis
Y N Rheumatism
Y N Ulcers
Y N Diabetes
Y N Hypoglycemia
Y N Kidney Problems
Y N Renal Dialysis
Y N Leukemia
Y N Sickle Cell Disease
Y N Blood Disease
Y N Blood Transfusion
Y N Excessive Bleeding
Y N Hemophilia
Y N Lung Disease
Y N Tuberculosis
Y N Tumors or Growths
Y N Anemia
Y N Thyroid Disease
Y N Tonsillitis
Y N Artificial Joint/Pins/Screws
Y N Do you have any serious illness not listed?

_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my personal or medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature of patient or guardian:_____ Date: _____