Welcome

1 about you

Today's Date: ____ /____ /____ File #: _____

Patient Name: _____
LAST FIRST M.I.

What You Prefer To Be Called:_____ ☐ Male ☐ Female

Birthdate: ___ /___ /___ Age: ____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #:(_____) _____ _____

Work Phone #:(_____) _____ Ext: _____

Cell Phone #:(_____) _____

E-Mail /Address: _____

Referred by: _____
(If doctor, please give phone number & address.)

Phone #: (_____) ____ _____

Address: _____

_____
CITY STATE ZIP

Employer: _____ How Long _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

Spouse's Name:_____

Do you have children? ☐ Yes ☐ No How many? _____

2 insurance info

Primary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #) : _____

Insured's Name: _____

Relation: _____ Date of Birth: __ /__ /__

Insured's Employer: _____

Secondary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #) : _____

Insured's Name: _____

Relation: _____ Date of Birth: __ /__ /__

Insured's Employer: _____

3 account info

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Drivers License #: _____

Work Phone #: (_____) _____ Ext: __

4 in event of emergency

Whom should we contact? _____

Relation:_____

Home Phone #:(_____) _____

Work Phone #:(_____) _____ Ext: ____

Cell Phone #:(_____) _____

Who is your Medical Doctor _____

Medical Doctor's Phone #: (____) _____

please continue on back

7621 Trenholm Road Ext • Columbia SC 29223 • 803.699.9989

dental information

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Dentist: _____ Phone #: (___) _____
NAME

Last Dental exam: _____ / _____ / _____ Last Dental X-rays: _____ / _____ / _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (circle one) (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

medical history

What medications are you taking? ☐ Nerve Pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers

☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis

☐ Other(s), please list: _____

Have you ever taken Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

Do you have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surg./Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Xray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical condition(s) you have or ever had: _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin

☐ Dental Anesthetics ☐ Foods: _____ ☐ Others: _____

Are you Pregnant? ☐ Yes/How long? _____ ☐ No

☐ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

☐ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____ / _____ / _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE
(OFFICE USE)

_____ ___/___/___
Initials Date

Comments

_____ ___/___/___
Initials Date

Comments

_____ ___/___/___
Initials Date

Comments