651 Saint Andrews Blvd.
Charleston, SC 29407 (843) 571-6795

MEDICAL HISTORY

Name ________________________________ Date of Birth ______________________
Address ____
SS# ______________________ Cell Phone ______________________ Marital Status ______________________
Home Phone ______________________________ Email ______________________
Occupation ____
Place of Business ______________________________ Work Phone ______________________
Dental Insurance Carrier ______________________________ ID No. ______________________
Person Responsible for Account ______________________________
Address ______________________________ Referred by ______________________
____
Physicians Name ______________________________ Dr. Phone No. ______________________
Date of last physical exam ______________________________ General Health ______________________
Are you under a physicians care now? ______________________________
Are you allergic to any drugs? ______________________________ If so, what? ______________________
Medication, drugs or pills taken in the last six months? ______________________________
Do you have a history or currently have any of the following?

_______ Abnormal Blood Pressure
_______ AIDS/HIV
_______ Allergies
_______ Alzheimers
_______ Anaphylaxis
_______ Anemia
_______ Angina
_______ Arthritis/Gout
_______ Artificial Joints
_______ Artificial Heart Valve
_______ Asthma
_______ Bisphosphonates
_______ Bleeding Problems
_______ Blood Disease
_______ Breathing Problem
_______ Bruise Easily
_______ Cancer
_______ Chest Pains
_______ Cold Sores/Fever Blisters
_______ Congenital Heart Disorder
_______ Convulsions
_______ Cortisone Medication
_______ Diabetes
_______ Drug Addiction
_______ Easily Winded
_______ Emphysema
_______ Epilepsy/Seizures
_______ Excessive Thirst
_______ Fainting Spells/Dizziness
_______ Frequent Cough
_______ Frequent Diarrhea
_______ Glaucoma
_______ Hay Fever
_______ Head Injuries
_______ Heart Attack/Failure
_______ Heart Disease
_______ Heart Murmur
_______ Hemophilia
_______ Hepatitis
_______ Herpes
_______ Hives/Rash
_______ Hypoglycemia
_______ Irregular Heartbeat
_______ Jaundice
_______ Kidney Disease
_______ Latex Allergy
_______ Leukemia
_______ Liver Disease
_______ Lung Disease
_______ Multiple Sclerosis
_______ Nervous Disorders
_______ Pacemaker
_______ Pain in Jaw Joints
_______ Psychiatric Treatment
_______ Radiation/Chemotherapy
_______ Respiratory Problems
_______ Rheumatic Fever
_______ Rheumatism
_______ Scarlet Fever
_______ Shingles
_______ Sickle Cell Disease
_______ Sinus Problems
_______ Spinda Bifida
_______ Stomach Problems
_______ Stroke
_______ Swelling
_______ Tuberculosis
_______ Thyroid Disorder
_______ Tonsilitis
_______ Tumors
_______ Ulcers
_______ Weight Loss

Have you ever had a blood transfusion? ______________________________
Have you ever had a serious illness not listed above? ______________________________
Are you on a special diet? ______________________________
Are you pregnant? ______________________ Expected delivery date? ______________________
Do you use tobacco? ______________ How much? ______________ How often? ______________

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DENTAL HISTORY

Date of last dental visit? ________________________________ How often do you brush your teeth? ___________________

Do you use dental floss?___________________________ How often? ____

Do your gums bleed? _________________________ When? ____

Do you have bad breath? ____________________ Does food get lodged between your teeth?_______________________

Are your teeth sensitive? _____________________ Describe ____

How do you feel about your teeth in general? ____

Do you like your smile? ____

Are you in any dental discomfort? ____

Are you apprehensive about dental care? ____

Do you have an interest in cosmetic dentistry? ____

I ____, have received a copy of this office's
PLEASE PRINT NAME

Notice of Privacy Practices (HIPAA).

____ ___________________________
SIGNATURE DATE