Hilton Head Dental Team

Date _____

How did you hear about us? _____

Whom may we thank for referring you? _____

Name of previous dentist _____

Patient Information

Patient Name _____ Nickname _____

Social Security # _____ Birthdate: _____ Age _____ Male or Female

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ @ _____ .com

Employed by _____ Occupation _____

Married Single Divorced Widowed Spouse's Name _____

Emergency Contact _____ Relation _____ Phone # _____

Account Information

Person Responsible _____ Relationship to Patient _____

Social Security # _____ Birthdate: _____ Age _____ Male or Female

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ @ _____ .com

Employed by _____ Occupation _____

Married Single Divorced Widowed Spouse's Name _____

Dental Insurance

Insurance Company _____ Group # _____ Subscriber ID _____

Subscriber Name _____ Social Security # _____ Birthdate _____

Employed By _____ Date Employed _____

Secondary Insurance

Insurance Company _____ Group # _____ Subscriber ID _____

Subscriber Name _____ Social Security # _____ Birthdate _____

Employed By _____ Date Employed _____

Hilton Head Dental Team
Medical History

Patient Name (please print):_____ Date _____

Dental History (Please check any of the following that apply to you)

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Discomfort when chewing
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Bad breath/bad taste in mouth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped or shifting teeth in your mouth
- ❑ Grinding or clenching teeth

How long has it been since your last cleaning?

❑ Less than 1 yr ❑ 1-2 yrs ❑ 3-5 yrs ❑ over 5 yrs

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten
- ❑ Close spaces
- ❑ Replace silver fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match other teeth

Other? _____

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

❑ Dentures ❑ Partial Dentures
❑ Braces ❑ Periodontal (gum) treatments

What is most important about your visit today? _____

_____ _____ _____
Name of previous dentist Phone number City & State

Why did you leave your previous dentist? _____

_____

Previous dental experiences: _____

On a scale of 1 to 10 with 10 being the highest:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Sleep History

Have you ever had a sleep study or do you currently use a CPAP? ❑Yes ❑No
Does your partner say that you snore? ❑Yes ❑No
Do you take frequent naps during the day, or often feel tired? ❑Yes ❑No
Other: _____

Medical History

Have you been under the care of a medical doctor during the past two years? ❑Yes ❑No
If yes, for what? _____

Physician's name: _____ Last visit to Physician: _____

Do you have high blood pressure? ❑Yes ❑No What is your normal blood pressure? _____

Staff Use: BP: _____ / _____ Pulse: _____

Do you use tobacco? ❑Chew ❑smoke How often? _____ How long? _____

Do you consume alcohol? ❑Yes ❑No How many beverages per week? _____

Do you use any mood altering drugs other than those previously listed? ❑Yes ❑No _____

Are you allergic or have had a reaction to the following? if yes please list

Local Anesthetic	❑Yes ❑No	_____
Penicillin or other antibiotics	❑Yes ❑No	_____
Aspirin, Ibuprofen or Tylenol	❑Yes ❑No	_____
Codeine, Valium or other sedatives	❑Yes ❑No	_____
Latex or metals	❑Yes ❑No	_____
Other? _____		

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ❑Yes ❑No

If yes, please list: _____

_____

Are you currently taking any medications, drugs or pills? ❑Yes ❑No

If yes, please list name and dosage: _____

_____

_____

_____

Have you had or now have the following conditions or treatments:

AIDS	❑Yes ❑No	Heart condition _____	❑Yes ❑No
Allergies or hives	❑Yes ❑No	Heart murmur	❑Yes ❑No
Asthma	❑Yes ❑No	Heart pacemaker	❑Yes ❑No
Arthritis/Rheumatism	❑Yes ❑No	Heart surgery	❑Yes ❑No
Artificial heart valve	❑Yes ❑No	Hemophilia	❑Yes ❑No
Artificial joints- type _____	❑Yes ❑No	Hepatitis type _____	❑Yes ❑No
Bisphosphonates? _____	❑Yes ❑No	High blood pressure	❑Yes ❑No
Bleeding/Blood disorder	❑Yes ❑No	HIV positive	❑Yes ❑No
Blood Thinners (not incl. aspirin)	❑Yes ❑No	HPV	❑Yes ❑No
Bone disease or bone cancer	❑Yes ❑No	Kidney trouble	❑Yes ❑No
Bruise easily	❑Yes ❑No	Latex sensitivity	❑Yes ❑No
Cancer	❑Yes ❑No	Liver disease	❑Yes ❑No
Chemotherapy	❑Yes ❑No	Low blood pressure	❑Yes ❑No
Chest pain (Angina)	❑Yes ❑No	Heart valve defect	❑Yes ❑No
Chronic cough	❑Yes ❑No	Neurological disorders	❑Yes ❑No
Cold sores/ Fever blisters	❑Yes ❑No	Nervous/Anxious	❑Yes ❑No
Congenital heart disease	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Cortisone medicine	❑Yes ❑No	Psychiatric/Psychological care	❑Yes ❑No
Daily aspirin	❑Yes ❑No	Radiation therapy	❑Yes ❑No
Diabetes? Type _____	❑Yes ❑No	Rheumatic fever	❑Yes ❑No
Drug addiction	❑Yes ❑No	Sinus trouble	❑Yes ❑No
Emphysema	❑Yes ❑No	Sleep apnea/Snoring	❑Yes ❑No
Epilepsy or seizures	❑Yes ❑No	Stroke	❑Yes ❑No
Fainting or dizzy spells	❑Yes ❑No	Thyroid problems	❑Yes ❑No
Family history of diabetes	❑Yes ❑No	Tuberculosis (T.B.)	❑Yes ❑No
Glaucoma	❑Yes ❑No	Tumors	❑Yes ❑No
Heart attack	❑Yes ❑No	Ulcers/Reflux	❑Yes ❑No

Do you have a medical condition that requires you to take a pre-med before dental visits? ❑Yes ❑No
If yes, which antibiotic do you take: _____

Any disease, condition or problem not listed: _____

Women

Are you pregnant or planning a pregnancy? ❑Yes ❑No

If yes, due date: _____

Are you a nursing mother? ❑Yes ❑No

Are you taking birth control pills? ❑Yes ❑No

Patient Name (Please Print) _____

Patient/Parent Signature _____ Date _____

Doctor/Staff Signature _____ Date _____