



**Patient Information**

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Sex \_\_\_\_\_  
(First) (Middle) (Last)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Patient's Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status: \_\_\_\_\_ Are you a student?  Y  N What school do you attend? \_\_\_\_\_

Emergency contact: \_\_\_\_\_  
(Name) (Phone number) (Relation)

Please indicate your preferred method of contact: \_\_\_\_\_ E-mail address \_\_\_\_\_

Would you like to receive text messages to confirm your dental appointments?  Y  N

Would you like to be contacted via email to confirm your dental appointments?  Y  N

How did you hear about Shallotte Family Dentistry? \_\_\_\_\_

**Dental Insurance Information**

Primary Insured's Name \_\_\_\_\_ Insured's Soc. Sec. No. \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Primary Insured's Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insurance Co. Phone No. \_\_\_\_\_

Insurance Co address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Subscriber No. \_\_\_\_\_ Group No. \_\_\_\_\_ Do you have a secondary dental insurance:  Y  N

**Responsible Party Information**

**(Please fill out if someone other than yourself is financially responsible for your account.)**

Name \_\_\_\_\_ Relation to self: \_\_\_\_\_

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address if different from above \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient / Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**MEDICAL HISTORY:** Do you currently have or have you ever had any of the following?

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Acid Reflux/GERD                          | <input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Palsy          | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease               | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Disorder   |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy/Radiation  | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                | <input type="checkbox"/> Y <input type="checkbox"/> N STD/ Venereal Disease   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies/Seasonal Allergies              | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery               | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alzheimer                                 | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsion/Epilepsy     | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis: Type _____       | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid: Type _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                                    | <input type="checkbox"/> Y <input type="checkbox"/> N Cholesterol             | <input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS                    | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety                                   | If yes: <input type="checkbox"/> High <input type="checkbox"/> Low            | <input type="checkbox"/> Y <input type="checkbox"/> N Immune Suppressive Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Tumors/Growths  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                                 | <input type="checkbox"/> Y <input type="checkbox"/> N Depression              | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems             | <input type="checkbox"/> Y <input type="checkbox"/> N ODD (Oppositional Defiant Disorder)                                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                                    | <input type="checkbox"/> Y <input type="checkbox"/> N Dementia                | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease               | <input type="checkbox"/> Y <input type="checkbox"/> N OCD (Obsessive Compulsive Disorder)                                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joints<br>or joint replacement | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes: Type _____    | <input type="checkbox"/> Y <input type="checkbox"/> N Lung Problems               | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autism                                    | <input type="checkbox"/> Y <input type="checkbox"/> N Dialysis                | <input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorder             | <b>Do you take an antibiotic prior to your dental appointments?</b> <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorder                         | <input type="checkbox"/> Y <input type="checkbox"/> N Drug/Alcohol Abuse      | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous System Disorder     |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Pressure                            | <input type="checkbox"/> Y <input type="checkbox"/> N Eating Disorder         | <input type="checkbox"/> Y <input type="checkbox"/> N Parkinson's disease         |   |
| If yes: <input type="checkbox"/> High <input type="checkbox"/> Low                              | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells         | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever             |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis                                | <input type="checkbox"/> Y <input type="checkbox"/> N Handicap/Disabilities   | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                    | <b>WOMEN:</b>   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer: Type _____                        | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches/Migraines     | <input type="checkbox"/> Y <input type="checkbox"/> N Smoker/Tobacco Use          | Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N   |
|   | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment      |   | Are you nursing? <input type="checkbox"/> Y <input type="checkbox"/> N  |

Have you ever taken a bisphosphonate medication by mouth or by IV? (Examples of this type of medication may include but are not limited to: Fosamax, Boniva, Aredia, Zometa, and Actonel)  Y  N Please explain: \_\_\_\_\_

Have you experienced any other medical conditions not listed above?  Y  N Please list: \_\_\_\_\_

Are you presently under the care of a physician?  Y  N Physicians Name: \_\_\_\_\_ Reason for care \_\_\_\_\_

Have you ever been hospitalized?  Y  N Please explain: \_\_\_\_\_

**ALLERGIES:** Are you allergic to any of the following?

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Amoxicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine           | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Red Dye               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin     | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetic | <input type="checkbox"/> Y <input type="checkbox"/> N Latex        | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfur                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clindamycin | <input type="checkbox"/> Y <input type="checkbox"/> N Eggs              | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   | <input type="checkbox"/> Y <input type="checkbox"/> N Tylenol/Acetaminophen |

Are you allergic to any other medications or foods that are not listed above? \_\_\_\_\_

**DENTAL HISTORY:**

What is the reason for your dental visit today? \_\_\_\_\_

Have you ever had a problem associated with previous dental work?  Y  N Please explain: \_\_\_\_\_

Name of your previous dentist: \_\_\_\_\_ Date of your last dental visit: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Do you brush your teeth daily?     | <input type="checkbox"/> Y <input type="checkbox"/> N Do your gums bleed while brushing or flossing your teeth? |
| <input type="checkbox"/> Y <input type="checkbox"/> N Do you use dental floss?           | <input type="checkbox"/> Y <input type="checkbox"/> N Do you avoid brushing areas of your mouth due to pain?    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Do you bite your nails?            | <input type="checkbox"/> Y <input type="checkbox"/> N Are you a mouth breather?                                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Do you grind or clench your teeth? | <input type="checkbox"/> Y <input type="checkbox"/> N Have you had a facial or jaw injury?                      |

**MEDICATIONS:** Please list all the medications, vitamins and supplements you are currently taking. If you have a list prepared please give this to the receptionist so it can be scanned into your chart.

Medication and Dose	How much do you take and when?	What do you take it for?	Date started

How would you like your smile to look? \_\_\_\_\_

If there any information you feel we should know regarding your dental treatment, please let us know. \_\_\_\_\_

**\*\* By signing below you are agreeing that the information above is accurate and complete to the best of your knowledge and you have provided Shallotte Family Dentistry with all the information needed to insure you have the most proper and safest care possible.**

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_