CAROLINA DENTISTRY

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Patient Information

Print name_____ Date: _____
Last *First* *MI*

Male ☐Female ☐ Marital Status: Single ☐ Married ☐ Child ☐ other: _____

Date of Birth: _____ S.S. #: _____ E-mail: _____

Home Address: _____
Street *City* *State* *Zip Code*

Cell Phone: _____ Home Phone: _____

Work Phone: _____Dental Insurance: _____

Employer: _____ Occupation: _____

Preferred Pharmacy (name, address, phone): _____

Medical History

1. Are you currently undergoing medical treatment? Please Explain.

   _____

2. Please list all medication that you are currently taking.

   _____

3. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?

   _____

4. Are you sensitive or allergic to latex?

   _____

5. Are you allergic (hives or swelling) to any drugs? If so, which ones?

   _____

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6. Are you taking any blood thinners? If so, list them here.

_____

7. Are you pregnant? _____ Due Date _____

8. List any surgeries you have had:

_____

Mark if you have any of the following conditions.

Heart Condition		Prosthetic Joints		Tuberculosis	
Bleeding Disorder		Hepatitis		Thyroid Disease	
History of Stroke/Heart Attack		Kidney Disease		Cancer or Tumors	
Diabetes		Arthritis		Anxiety, Depression	
Artificial Heart Valve		Lupus		Drug Addiction	
Lung Disease		Seizures			

Dental History

What is your primary dental concern? _____

Mark if you have any of the following conditions.

Bleeding Sensitive Gums		Food Trapping between Teeth		Clicking/Popping Jaw	
Sensitivity to hot/cold		Mobile teeth		Mouth Sores	
Sensitivity to sweets		Sensitivity to biting		Halitosis	
Broken fillings		Grinding/Clenching			

Do you have any anxiety or fear related to dental treatment? Yes ☐ No☐

Would you need to have Nitrous Oxide/Laughing Gas during appointments? Yes☐ No☐

Is there anything about your teeth that you want to change?_____

To the best of my knowledge, all the preceding answers and information are true and correct. If I have changes in my health, I will inform the doctor at the next appointment.

_____ _____

Patient/Guardian Signature: *Date:*

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