South Hill
FAMILY DENTAL

Patient Name:_____ Date of Birth:_____

Home Address:_____City:_____State:____Zip:_____

Home Phone:_____Cell:_____Work:_____Email:_____

Which of these numbers do you prefer to be contacted?_____

Spouse's Name/Number_____ Emergency Contact:_____

How did you hear about our office?_____

Primary Dental Insurance

Insured
Employer_____

Ins. Co. Name_____

Address:_____

Tel.#_____Group#_____

Insured Name_____Relation_____

Insured Birthdate_____Insured S.S.#._____

Secondary Dental Insurance

Insured
Employer_____

Ins. Co. Name_____

Address:_____

Tel.#_____Group#_____

Insured Name_____Relation_____

Insured Birthdate_____Insured S.S.#._____

Who will be responsible for your account? (Please circle) Self Spouse Father Mother Other

Name_____ Relation_____ S.S.#._____

Address_____ Phone#_____

Name of previous dentist:_____ Date of last dental exam:_____

Name of Physician:_____ Date of last medical exam:_____

Have you been hospitalized in the past three years? If so please explain?_____

Are you apprehensive about dental treatment? Y O N O
Do you have difficulty in chewing your food? Y O N O
Do your gums bleed when you floss? Y O N O
Do you have sensitive teeth with:
Hot foods or liquids? Y O N O Cold foods or liquids? Y O N O
Sweets? Y O N O
How often do you Brush?_____ Floss?_____
Do you clench or grind your teeth? Y O N O
Does it hurt when you open your mouth wide or chew certain foods? Y O N O
Does your jaw hurt when you wake up in the morning? Y O N O

HAVE YOU EXPERIENCED OR HAD:

Chest Pain (Angina)	Y ○	N ○	Dizziness, Fainting	Y ○	N ○
Shortness of Breath	Y ○	N ○	Recent Weight Change	Y ○	N ○
Headaches	Y ○	N ○	Blurred Vision	Y ○	N ○
Bleeding Problems	Y ○	N ○	Sinus Problems	Y ○	N ○
Difficulty Swallowing	Y ○	N ○	Frequent Urination	Y ○	N ○
Dry Mouth	Y ○	N ○	Frequent Nausea	Y ○	N ○
Excessive Thirst	Y ○	N ○	Contact Lenses	Y ○	N ○
Heart Disease, Artificial Valve	Y ○	N ○	Stroke	Y ○	N ○
Heart Murmur	Y ○	N ○	Rheumatic Fever	Y ○	N ○
Heart Attack	Y ○	N ○	Sexually Transmitted		
High Blood Pressure	Y ○	N ○	Disease	Y ○	N ○
Asthma or Lung Disease	Y ○	N ○	AIDS/HIV	Y ○	N ○
Tumors	Y ○	N ○	Hepatitis/Liver Disease	Y ○	N ○
Arthritis	Y ○	N ○	Eye or Skin Disease	Y ○	N ○
Anemia	Y ○	N ○	Jaundice	Y ○	N ○
Herpes/Cold Sores	Y ○	N ○	Kidney/Bladder Disease	Y ○	N ○
Thyroid Disease	Y ○	N ○	Diabetes	Y ○	N ○
Ulcers/Stomach Problems	Y ○	N ○	Blood Transfusion	Y ○	N ○
Pacemaker/Prosthetic Heart	Y ○	N ○	Artificial Joints/Implants	Y ○	N ○
Chemo/Radiation Treatment	Y ○	N ○	Psychiatric Care	Y ○	N ○
Cancer	Y ○	N ○			

Do you have a **prosthetic joint replacement**? _____If so,what and date of placement_____

Do you have **heart valve replacement**? _____ Date of placement_____

Allergies to medications_____ Allergies to latex_____

Do you have any other diseases or medical problems that are NOT listed on this form?

_____

DO YOU TAKE:

Recreational drugs	Y ○	N ○	Tobacco in any form	Y ○	N ○
Medications or natural remedies	Y ○	N ○	Alcohol	Y ○	N ○

Please list all medications:

_____

WOMEN:

Are you or could you be pregnant	Y ○	N ○	Taking birth control pills	Y ○	N ○
Are you nursing	Y ○	N ○			

_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTIST OF ANY CHANGE IN MY HEALTH AND OR MEDICATION. I have read and understand the following: (Please initial next to agreement)

_____ Appointment policy **_____ Insurance/Financial Agreement**

_____ HIPAA privacy policy Agreement **_____ Photo for identification purposes (not used for marketing purposes)**

PATIENT'S SIGNATURE_____ DATE:_____

DOCTOR'S SIGNATURE_____ DATE:_____

SUBMIT