CAROLINA DENTAL CARE

WELCOME TO OUR OFFICE

Today's Date _____

Name _____ Date of Birth _____ S.S.# _____
Last First M.I.

Address _____ Marital Status _____ Sex ☐ M ☐ F

_____ Home Phone _____

Place of Employment _____ Work Phone _____

Full Name of Spouse/Parent _____ Cell # _____

Email: _____

Who may we thank for referring you to our office? _____

Person responsible for payment of account _____

Dental Insurance Company _____

Medical Physician's Name _____ Drug Store Name _____

In Case of Emergency Notify _____ Phone _____

PATIENT MEDICAL HISTORY

☐ Yes ☐ No Are you under any Medical treatment now?
If so, what? _____

☐ Yes ☐ No Are you allergic to **ANYTHING?** (If so, list under medical alert) →

☐ Yes ☐ No Have you had any major operations?
If so, what? _____

☐ Yes ☐ No Are you now taking drugs or medications? (If so, list under Current Medications) →

☐ Yes ☐ No Have you **ever** had cancer or radiation treatment for cancer?

☐ Yes ☐ No Are you being treated or have you **ever** been treated for **Osteoporosis?**
How many years? _____

☐ Yes ☐ No Have you **ever** taken Bisphosphonates? (Fosamax, Zometa, Reclast?)

☐ Yes ☐ No Have you received any donor organs, artificial heart valves, vessels, joint implants, or use a pacemaker?

☐ Yes ☐ No Are you currently taking blood thinners?

☐ Yes ☐ No Do you have to premedicate with an antibiotic prior to dental visits?

☐ Yes ☐ No Have you ever had any of the following?

☐ Heart Ailment	☐ Any Liver Disease
☐ High Blood Pressure	☐ Any Kidney Disease
☐ Low Blood Pressure	☐ Any Stomach Disease
☐ Respiratory Disease	☐ Sexually Transmitted Disease
☐ TB	☐ AIDS or AIDS related disorders
☐ Diabetes	☐ Yellow Jaundice
☐ Rheumatic Fever	☐ Hepatitis
☐ Arthritis	☐ Epilepsy or Seizures
☐ Tumors or Growths	☐ Nervous Disorder
☐ Any Blood Disease	☐ Asthma
☐ Any Bleeding Disorder	☐ Joint Replacement

☐ Other (Specify) _____

MEDICAL ALERT

CURRENT MEDICATION

COMMENTS

PATIENT MEDICAL HISTORY

☐ Yes ☐ No Have you ever had an accident involving your head or jaw?

☐ Yes ☐ No Have you ever taken cortisone or steroids for a period longer than 2 weeks?

When? _____ How long? _____

☐ Yes ☐ No Are you allergic to any materials resulting in hives, asthma, eczema, etc.?

☐ Yes ☐ No Have you ever had sensitivity to costume jewelry or any type of metal sensitivity?

☐ Yes ☐ No Have you had any wounds that healed slowly?

☐ Yes ☐ No Do you use alcohol or drugs? How Often? _____

☐ Yes ☐ No Do you use cigarettes, cigars, snuff, chewing tobacco? How Often? _____

How many years have you used tobacco? _____

☐ Yes ☐ No Do you have any other problems not listed above?

☐ Yes ☐ No Are you pregnant? If yes, what is your due date? _____

☐ Yes ☐ No Have you gained or lost 20 pounds in the past year?

MEDICAL HISTORY RECERTIFICATION (Staff Use Only)

I certify that there have been no changes in my health except as noted below.

Date	Change	Signature

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge. I fully understand that my insurance benefit is an arrangement between myself and the insurance company and I am responsible for the entire balance. I understand I will be charged 1.5% interest monthly if my account is over 90 days.

TREATMENT AUTHORIZATION: I hereby grant authority to the Carolina Dental Care who is in charge of the patient whose name appears on this health history form, to obtain any and all health information from any physician(s) and/or pharmacy(s), to administer any treatment and to administer such X-rays, anesthetics, sedatives, or nitrous oxide, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

X_____ _____ _____

SIGNATURE ***Relationship to Patient*** ***Date***

I have received and/or read a copy of this office's Notice of Privacy Practices and Acknowledgement of Receipt of Notice of Privacy Practices

X_____ _____ _____

SIGNATURE ***Relationship to Patient*** ***Date***