ABBEVILLE Dentistry

Experience the Difference
68-SMILE

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

DATE ____ /____ / _______

PATIENT INFORMATION

Name ____
Last Name First Name Middle Initial

Address ______________________ City ___________________ State ________ Zip __________

Home Phone ___________________ Cell Phone ___________________ Work Phone ___________________

Email Address ________________________________ Sex ☐ M ☐ F Ht ________ Wt ________

Social Security # __________-______-__________ ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

DOB ______ / ______ / __________ Driver's License # __________________________

Employer ____________________________________ Occupation ________________________________

How did you hear about us?

☐ Radio ☐ Television ☐ Insurance

☐ Internet ☐ Personal Reference ☐ Walk-in

☐ Local Event ________________________ ☐ Other ________________________

In case of emergency who should we contact? __________________________ Phone ___________________

Person responsible for account ____

PRIMARY DENTAL INSURANCE

PRIMARY INSURED'S INFORMATION ONLY REQUIRED BELOW

Name ____
Last Name First Name Middle Initial

Relationship to Patient ______________________ DOB ______ / ______ / __________

Social Security # __________-______-__________ Contact Number ___________________

Address ______________________ City ___________________ State ________ Zip __________

Employer ____

Insurance Company ____________________________________ Phone ______________________________

Insurance Company Address ____

Subscriber ID # ____________________________________ Group # ______________________________

SIGNATURE ____ DATE ____ /____ / _______

DENTAL HISTORY

Former Dentist ______________________________ City ________________________ State __________________

Date of last dental visit ___________________________ Date of last x-rays __________________________________

How often do you brush? ___________________________ How often do you floss? ___________________________

Please check all that apply:

Bad Breath	☐	Loose teeth or broken fillings.........	☐	Sensitivity to sweets	☐
Bleeding Gums	☐	Orthodontic treatment	☐	Sensitivity when biting	☐
Blisters on lips/mouth	☐	Pain around ear	☐	Frequent headaches	☐
Fingernail biting	☐	Periodontal treatment	☐	Jaw/head/neck injuries	☐
Grinding teeth	☐	Sensitivity to cold	☐	Jaw difficulty – clicking/pain	☐
Lip/cheek biting	☐	Sensitivity to heat	☐	Tooth pain	☐

MEDICAL HISTORY

Physician's Name ______________________________________ Date of last visit ______________________________

	Yes	No
Are you currently under medical treatment?	☐	☐
Have you ever had any serious illnesses or operations?	☐	☐
Are you taking or have you ever taken:		
Boniva (Bandronate)	☐	☐
Forsamax (Aledronate)	☐	☐
Actonel (Risedronate)	☐	☐
Aredia (Pamidronate)	☐	☐
Didronel (Etidronate)	☐	☐
Zometa (Zoledronic acid)	☐	☐
Are you currently taking any medication?	☐	☐

Please list (including pre-meds):_______________________________

____

	Yes	No
Do you smoke?	☐	☐
Do you use alcohol?	☐	☐
Do you use cocaine or other drugs?	☐	☐

	Yes	No
Do you wear contact lenses?	☐	☐
Have you had any allergic reactions to the following		
Local Anesthetics (eg. Novocain)...............	☐	☐
Antibiotics	☐	☐
Sulfa Drugs..	☐	☐
Barbituates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Asprin	☐	☐
Latex	☐	☐
Penicillin	☐	☐
Other	☐	☐
(Women only) Are you:		
Pregnant	☐	☐
Nursing	☐	☐
Taking birth control pills	☐	☐

Please check all that apply: (circle when aplicable)

- ☐ Prosthetic Cardiac Valve .... premedication? Y/N
- ☐ Previous Infective Endocarditis ...... premedication? Y/N
- ☐ Congenital Heart Disease .... premedication? Y/N
- ☐ Cardiac Transplantation .... premedication? Y/N
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial joints Date: ______________
- ☐ Asthma
- ☐ Bleeding abnormally with extractions/surgery
- ☐ Blood disease
- ☐ Cancer (type) ________________
- ☐ Dependecny: Alcohol or Chemical
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone Treatments
- ☐ Cough: persistent or bloody
- ☐ Diabetes: Type I / Type II
- ☐ Blood Thinners
- ☐ High blood pressure
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Hepatitis (type) _____
- ☐ Herpes
- ☐ Low blood pressure
- ☐ HIV positive
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Skin rash
- ☐ Stroke Date: __________
- ☐ Swelling of feet/ankles
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth
- ☐ Ulcer
- ☐ Venereal disease

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. __________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________________________ Date _____ / _____ / _______