CAROLINA DENTAL CARE

We would like to get to know you better!

Patient Name: ______________________ Date: __________________ ◊ Male ◊ Female
Address: ____________________________ City/State: ______________ Zip: __________
Home Phone: ________________ Cell: ________________ Work: ________________
Date of Birth: ________________ Social Security: ____________________ Age: ______

IF CHILD:
Parent Name: ____________________ Work Phone: __________ Parents SS # ____________
Parent Employer: ____________________ Parent Occupation: ______________________

SELF: Employer: ____________________ Occupation: ______________________________

SPOUSE: Name: ____________________ Spouse's Occupation: ______________________
Spouse's Employer: ________________ Spouse's Work Phone: ______________________
Whom may we thank for referring you in our office: ______________________________

EMERGENCY:

Person to contact in case of emergency ______________ Relationship__________ Phone Number ____________

DENTAL HISTORY:

Former Dentist: ________________ Last Visit: ________________ Date of Last Dental X-rays __________
Reason for today's visit: ____
How often do you brush ? __________ Floss? __________ Use Mouthwash ? ______________

Please check any of the following conditions that apply to you:

☐ Bad Breath	☐ Grinding Teeth	☐ Periodontal (Gum) Disease	☐ Bleeding Gums
☐ Mouth Sores	☐ Clicking or Popping Jaw	☐ Loose Teeth or Broken Fillings	☐ Sensitivity when Chewing
☐ Sensitivity to Hot	☐ Sensitivity to Cold	☐ Food Collects Between Teeth	☐ Sensitivity when Biting

	YES	NO	COMMENTS
Are you happy with your Smile?	☐	☐	______________
Have you had Orthodontics (Braces)	☐	☐	______________
Do you think you will eventually need dentures?	☐	☐	______________
Have you ever had a reaction to anesthetic?	☐	☐	______________
Do you avoid brushing part of your mouth?	☐	☐	______________
Do you smoke or use smokeless tobacco?	☐	☐	______________
Have you ever had any teeth removed?	☐	☐	______________

If you could make one change to your teeth what would it be? ______________________________
If it has been more than 1 year since your last dental visit what kept you from going to the dentist?______________
If you could eliminate one part of the dental visit, what would it be ? ______________________

MEDICAL HISTORY:

Physician: ______________ Physician Telephone;______________Allergies:______________
Please list all medications you are currently taking:______________________________
Current Health Conditions:____

WOMEN ONLY : Are you pregnant: ☐YES ☐NO Nursing: ☐YES ☐NO Taking Birth Control Pills: ☐YES ☐NO

ALL PATIENTS: Do you have a history of the following?

☐ Anemia	☐ Artificial Joints	☐ Artificial Heart Valve	☐ Heart Murmur
☐ High Blood Pressure	☐ Mitral Valve Prolapse	☐ Rhematic Fever	☐ Circulatory Problems
☐ Fainting	☐ Cortisone Treatments	☐ Arthritis, Rheumatism	☐Cancer
☐ Asthma	☐ Chemical Dependency	☐ Cough, Persistent	☐ Cough up Blood
☐ Diabetes	☐ Epilepsy	☐ Glaucoma	☐ Headaches
☐ Tuberculosis	☐ Venereal Disease	☐ Kidney Disease	☐ Sensitivity when Biting
☐ Hepatitis	☐ HIV Positive/ AIDS	☐ Other ______________	

AUTHORIZATION:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.

Patient (or Parent's) Signature: ______________________________ Date: ______________