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

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: _____