CHARLESTON CENTER
FOR COSMETIC & RESTORATIVE DENTISTRY, LLC

Welcome to your new dental office. Our commitment is to provide you with personal care utilizing the best possible preventive and cosmetic dental techniques. Please take time to carefully complete the following information.

Name_____ Nickname_____ Date_____

Address_____City_____State_____Zip_____

☐Home Phone _____ ☐Work Phone _____ ☐Cell Phone_____

(Please mark all that apply). Sex: M___ F___ Marital Status___ Birthdate_____Age___ SS#_____

Driver's license number_____ E-Mail Address_____

Would you like to receive appointment or other reminders via text messages? **Y/N** Email? **Y/N** Email Newsletters? **Y/N**

Patient Employed By_____Occupation_____

Spouse Name_____Occupation_____

Spouse Birthdate _____Spouse Cell #_____Spouse Work #_____Spouse SS#_____

In Case of Emergency Contact_____Phone_____Relationship_____

DENTAL INSURANCE INFORMATION

Name of Insured_____SS#_____Birthdate_____

Insured's Employer_____

Dental Insurance Company Name_____Address (CSZ)_____

Phone_____ Subscriber ID#_____Group#_____Policy#_____

Is Patient Covered by Additional DENTAL Insurance? YES _____ NO _____

Name of Insured_____SS#_____Birthdate_____

Insured's Employer_____

Dental Insurance Company Name_____Address (CSZ)_____

Phone_____ Subscriber ID#_____Group#_____Policy#_____

How did you hear about us? Another patient? _____ If so, who may we thank for the referral?_____

Website?___ Google search?___ Other search engine?___ Print ad?___ Dental/Medical Professional?____

Professional's Name?_____ Other Referral?_____

Purpose of today's visit_____

List any previous major dental treatment_____

Date of last dental exam_____ Date of last full mouth x-rays_____ Name of previous dentist_____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Please include OTC products, vitamins, herbs & supplements _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following (Circle)? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other *(Please include foods).* If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Other:_____

Have you ever had any serious illness not listed above? Yes____No_____If yes, please explain: _____

Do you have discomfort with your teeth, jaw or ear?_____ Do you have discomfort, sores or lumps in your head or neck?_____

Are you confident in your ability to properly clean your teeth?_____ Do you floss?____ How often?_____

Are you very nervous about having dental treatment?_____ Have you had a traumatic dental experience? When?_____

Do you feel you will eventually lose all your teeth, even with proper care?_____ Do any members of your family, including parents, wear dentures?_____

Are you interested in saving your teeth?_____ Do you feel you chew efficiently?_____ Do you clench or grind your teeth?_____

Are you concerned about finances needed to return your mouth to health?_____

Are you frustrated because you are always having dental work every time you come to the dentist?_____

Are you pleased with the appearance of your teeth?_____ Have you ever whitened (bleached) your teeth? _____

I think my present state of dental health is: _____excellent_____good_____poor

I would like my dental health to be: _____excellent_____good_____poor

If by magic I could change anything about my teeth, it would be: _____

I hereby state that the answers to the questions above are correct to the best of my ability. I furthermore promise to take it upon myself to inform this office of any change in my medical history prior to subsequent dental treatments. I also give my consent for medical and dental professional consultation in regards to my medical or dental history and/or treatment I understand that I am financially responsible for all charges, regardless of any insurance involvement. I agree to pay all collection or legal fees, including interest charges associated with obtaining payment for the outstanding balance.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____