PATIENT INFORMATION

Welcome to our practice!
This confidential information will help us prepare for your visit.

NAME ◯ MRS ◯ MR ◯ MS ◯ REV ◯ DR	I PREFER TO BE ADDRESSED AS
BIRTHDATE	SS #
ADDRESS	EMAIL
I AM ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPARATED	WHOM MAY WE THANK FOR REFERRING YOU?

HOME PHONE #	CELL PHONE #	WORK PHONE #
EMPLOYER ADDRESS	EMPLOYER NAME	OCCUPATION

We may use an automated appointment reminder system that can send you convenient email, text messages, and/or postcards. We may also call and if necessary leave brief voicemail messages.

If you would prefer **NOT** to receive routine reminders from us via certain methods, please indicate below:

☐ NO TEXT MESSAGES ☐ NO EMAILS ☐ NO CELL PHONE ☐ NO HOME PHONE ☐ NO WORK PHONE ☐ NO POSTCARDS

FAMILY MEMBERS SEEN AS PATIENTS HERE	
SPOUSE'S NAME	SPOUSE'S BIRTHDATE

SPOUSE'S SS#	SPOUSE'S CELL PHONE #	SPOUSE'S WORK PHONE #
SPOUSE'S EMPLOYER ADDRESS	SPOUSE'S EMPLOYER NAME	SPOUSE'S OCCUPATION
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #	EMERGENCY CONTACT RELATIONSHIP

PERSON FINANCIALLY RESPONSIBLE ◯ SELF ◯ SPOUSE ◯ OTHER	RESPONSIBLE PARTY NAME (IF OTHER)	RESPONSIBLE PARTY PHONE # (IF OTHER)	RESPONSIBLE PARTY SS # (IF OTHER)
RESPONSIBLE PARTY ADDRESS (IF OTHER)		RESPONSIBLE PARTY RELATIONSHIP (IF OTHER)	
DENTAL INSURANCE COMPANY NAME	DENTAL INSURANCE COMPANY ADDRESS	DENTAL INSURANCE COMPANY PHONE #	GROUP #

CONCERNS I SEE ABOUT ACHIEVING OR MAINTAINING EXCELLENT DENTAL HEALTH ARE:

☐ I SEE NO OBSTACLES ☐ TIME AWAY FROM WORK OR OTHER OBLIGATIONS ☐ FEAR BECAUSE OF PAST DENTAL EXPERIENCES
☐ COST OF TREATMENT ☐ FEAR OF POSSIBLE DISCOMFORT, PAIN, OR INJECTIONS
☐ OTHER (PLEASE EXPLAIN)

I BELIEVE MY PRESENT STATE OF DENTAL HEALTH IS ◯ POOR ◯ FAIR ◯ GOOD ◯ EXCELLENT	I AM AWARE OF THE CURRENT DENTAL TREATMENT THAT I NEED ◯ YES ◯ NO

PLEASE SELECT ONE

◯ I AM SATISFIED WITH MY SMILE ◯ I AM CURIOUS HOW TO IMPROVE MY SMILE ◯ I AM NOT SATISFIED WITH MY SMILE

HEALTH HISTORY

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MY CURRENT MEDICAL HEALTH IS
◯ EXCELLENT ◯ GOOD ◯ FAIR ◯ POOR

I AM UNDER THE CARE OF A PHYSICIAN
◯ YES ◯ NO

PHYSICIAN NAME

PHYSICIAN PHONE #

PHYSICIAN ADDRESS

PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDE BOTH PRESCRIPTION & OVER THE COUNTER)

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING

☐ ANEMIA	☐ COLD SORES	☐ FEVER BLISTERS	☐ HIV/AIDS	☐ SCARLET FEVER
☐ ARTHRITIS	☐ COLITIS	☐ GLAUCOMA	☐ HOSPITALIZED	☐ SEVERE OR FREQUENT HEADACHES
☐ ARTIFICIAL JOINT	☐ DIABETES	☐ HEART ATTACK	☐ KIDNEY PROBLEMS	☐ SHINGLES
☐ ARTIFICIAL VALVE	☐ DIFFICULTY BREATHING	☐ HEART MURMUR	☐ MITRAL VALVE PROLAPSE	☐ SINUS PROBLEMS
☐ ASTHMA	☐ DRUG/ALCOHOL DEPENDENCE	☐ HEART SURGERY	☐ PACEMAKER	☐ STROKE
☐ BLOOD TRANSFUSION	☐ EMPHYSEMA	☐ HEMOPHILIA/BLEEDING	☐ PSYCHIATRIC PROBLEMS	☐ TUBERCULOSIS
☐ CANCER	☐ EPILEPSY/SEIZURES	☐ HEPATITIS	☐ RADIATION TREATMENT	☐ ULCERS
☐ CHEMOTHERAPY	☐ FAINTING	☐ HIGH/LOW BLOOD PRESSURE	☐ RHEUMATIC FEVER	☐ VENEREAL DISEASE

PLEASE CHECK ANY OF THE FOLLOWING DRUGS YOU HAVE USED AT ANY TIME
☐ ACTONEL ☐ AREDIA ☐ BIOPHOSPHONATES/BISPHOSPHONATES ☐ BONIVA ☐ DIDRONEL ☐ FOSAMAX ☐ SKELID ☐ ZOMETA

ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH ANY OF THE FOLLOWING SUBSTANCES
☐ ASPIRIN ☐ CODEINE ☐ DENTAL ANESTHETIC ☐ ERYTHROMYCIN ☐ LATEX ☐ PENICILLIN ☐ SULFA ☐ TETRACYCLINE
☐ OTHER (PLEASE LIST): ____________________

WOMEN ONLY
ARE YOU PREGNANT? ◯ YES ◯ NO   ARE YOU NURSING? ◯ YES ◯ NO   ARE YOU TAKING BIRTH CONTROL? ◯ YES ◯ NO

PLEASE SELECT ONE
◯ I CURRENTLY HAVE NO DENTAL PAIN, JAW PAIN, OR SENSITIVITY   ◯ I CURRENTLY HAVE SOME DENTAL PAIN, JAW PAIN, OR SENSITIVITY

PLEASE SELECT ONE
◯ MY MOUTH IS VERY COMFORTABLE   ◯ MY MOUTH IS MODERATELY COMFORTABLE   ◯ MY MOUTH IS UNCOMFORTABLE

The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: You may refuse to sign this acknowledgment.

I, ____ have recieved a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGMENT
- ☐ OTHER (PLEASE SPECIFY): ____

SIGNATURE OF OFFICE REPRESENTATIVE	DATE

843.553.5235 | 100 Berkeley Square Lane, Goose Creek, SC 29445 | GooseCreekDental.com