

EAST COOPER DENTAL EXCELLENCE

1100 Queensborough Blvd. Suite 103, Mt Pleasant SC 29464

Patient Information

Patient _____ Date: _____
Last First MI (Preferred Name)

E-mail: _____ Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

City State Zip Code

If you are completing this form for another person, what is your relationship to that person? _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Premed | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | OTHER: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis | |

• Are you taking any medicine(s) including non-prescription medicine? Yes No
If so, what? _____

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Yodle Yellow Pages Insurance Company Moultrie Work Mailer Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Insurance Plan Phone Number: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

For completion by dentist.

Comments on patient interview concerning medical history: _____

_____ Significant findings

from questionnaire or oral interview: _____

Dental management considerations: _____

(Date)

(Signature of Dentist)

Medical history update:

Date Comments Signature
