Welcome to Quillian's Corner Dental Care ..... where our patients experience true Southern Charm and State-of-the-art technology!

Date:______________ Patient's Full Name:____Nickname:________________

Why did you come to the dentist today? ____

Do you have any immediate concerns? Y N Please describe:____

MailingAddress: ____ City: ___________________________ Zip: _____________

Street Address(*REQUIRED*)____________________________________City: ____________________________ Zip: __________
Patient's Home # __________________ Work # _____________________ Pager/ Cell Tel # __________________________

Date of Birth_____/______/_____ Sex: M F Marital Status: S M W D Social Security Number: _______-_____-_________

Email Address: ________________________ Occupation: __________________________ Employer: _____________________

Please introduce us to your children. Please provide the names and ages of your children:

1) ________________ 2) ___________________ 3) __________________ 4) __________________ 5) _________________

In case of an emergency, who should we notify?____________________________________Tel.#___________________

Name of Spouse(if applicable) ____________________________Spouse Work Phone/Cellular:______________________

Whom may we thank for referring you ? Sign /Yellow Pages/ Friend/ Family/ Employee -: __________________________

Physician's Name _______________________________City _________________________ State _________

Former Dentist's Name ____________________________________City _________________________ State _________

***Why* are you changing dentists?____**

When was the *last time you had a dental exam* and dental cleaning? ____________ Were xrays taken? ______________________

Have you had your wisdom teeth removed?_________________

Are you *apprehensive about receiving treatment*? Y N If you are apprehensive, of what ? (be very specific)
____

Have you been told to *take an antibiotic* before dental treatment? Y N What antibiotic __________________________________

Have you had your teeth *bleached/ whitened*? Y N Have you had *braces*? Y N

Are you happy with your *smile*? Y N If not, what would you change?____

Have you ever been told you have *gum disease* ? Y N Do your *gums bleed* when you brush? Y N

Bleed when you *floss*? Y N Do you *smoke*? Y N

Do you have *pain or a clicking sound* when you open and close your mouth? Y N

Have you ever had any *serious problems with previous dental work*? Y N If Yes, Please describe:

____

Have you ever had any of the following diseases or medical problems? Please Circle Y or N

Heart trouble/ attack	Y N	FOSAMAX/ bisphosphonate	Y N	Sinus Trouble/ Asthma	Y N
Heart murmur as a child	Y N	Cortisone (steroid) medicine	Y N	Fainting or dizzy spells	Y N
Heart murmur currently	Y N	Diabetes	Y N	Cancer(?)_________	Y N
Heart Pacemaker	Y N	Stroke	Y N	Chemotherapy	Y N
Mitral valve prolapse	Y N	High blood pressure	Y N	Radiation	Y N
Artificial heart valve	Y N	Emphysema	Y N	Blood transfusion	Y N
Artificial joint	Y N	Tuberculosis	Y N	Hemophilia/Coumadin therapy	Y N
Hepatitis / Jaundice	Y N	Ulcers	Y N	Anemia	Y N
Rheumatic fever	Y N	Depression	Y N	Arthritis	Y N
HIV + / AIDS / ARC	Y N	Bulimia	Y N	Fever blisters	Y N
Epilepsy or seizures	Y N	Psychiatric treatment	Y N	Drug/Alcohol abuse	Y N

Are you ALLERGIC to any of the following? Codeine Y N Dental Anesthetics Y N Penicillin Y N
Erythromycin Y N Clindamycin Y N Latex Y N Other: ___________________________________

Please list ALL medications/herbs/over the counter drugs you are taking and WHY you are taking them.

1) ____ **for** ____

2) ____ **for** ____

3) ____ **for** ____

4) ____ **for** ____

Please list any other medical condition/congenital abnormalities that you have been or are being treated for:

____

Are you pregnant? Y N Possibly Are you nursing a baby? Y N

I affirm that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.

PATIENT SIGNATURE: ____
(OR PARENT OF MINOR)

INSURANCE INFORMATION

Primary Insured Party's Full Name: ____________________________ **Social Security Number:** ______--____--________

Relationship to Patient: Self / Spouse / Parent / Step Parent / Other ____________________

Employer: ______________________________ **Insurance Company Name:** ___________________________________

Ins. Address: ____ **Ins Phone #:**__________________

Group Name: ___________________________ **Group or Local Number:** _______________________________

Occupation of Spouse: ___________________________________ **Employer:** _____________________________________

Spouse's Date of Birth: _____/____/_________ **Spouse's Social Security Number:** ________— ______—___________