



Carolina Smile Center

Jeff T. Blank, DMD, PA

Patient Information

Date _____

Name ? Dr. ? Mr. ? Mrs. ? Ms. _____ Nickname _____

? Child ? Single ? Married ? Divorced ? Widowed Age _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Home Phone _____ Business Phone _____ Ext. _____ Cell Phone _____

Email Address _____ Social Security # _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Social Security # _____ Person Responsible for Bill _____

Dental Insurance ? Yes ? No If yes, Group Carrier _____ Group # _____

Has any member of your family been treated in our office ? ? Yes ? No Name _____

How did you hear about our office? _____

Call in case of emergency _____ Relationship _____ Phone _____

Reason for visit today _____

Medical Health

Name and address of physician _____

Physician's phone number _____ Last complete physical? _____

Overall general health ? Excellent ? Good ? Fair ? Poor Do you have a snoring problem? ? Yes ? No

Please check those conditions that now or have ever pertained to you:

Yes	No	Yes	No
?	? Heart Murmur or Congenital Heart Defect	?	? Joint Replacement Where? _____
?	? Heart Surgery or Heart Disease	?	? Migraines ? Frequent Headaches
?	? Rheumatic Fever	?	? Recent Weight Loss
?	? Heart Pacemaker	?	? Convulsions or Epilepsy
?	? Abnormal Blood Pressure ? High ? Low	?	? Dizziness or Fainting Spells
?	? Bleeding Problems	?	? Stroke
?	? Diabetes	?	? Lung Problems or Tuberculosis
?	? Kidney Disease	?	? Thyroid Disease
?	? Jaundice or Liver Disease	?	? Glaucoma
?	? Cancer ? Malignant ? Benign Where? _____	?	? Arthritis
?	? Radiation Treatment. If so, When? _____	?	? Chemical Dependency
?	? Hepatitis Type ? A ? B ? C	?	? Blood Disease ? Anemia ? Hemophilia
?	? Venereal Disease	?	? Stomach Ulcers ? Gastric Reflux
?	? Are you taking Blood Thinners i.e. Coumadin	?	? Sinus Trouble
?	? HIV ? AIDS	?	? Cold Sores ? Genital Herpes ? Shingles
?	? Females: Are you, or could you be pregnant?	?	? Are you currently under the care of a physician?

Are you allergic or sensitive to:

? ? Penicillin or other antibiotics? List others: _____

? ? Local Anesthetics like Novacaine

? ? Codeine

? ? Other Drugs or Foods (list) _____

Are you presently taking medication?

? ? If yes, please list and give reason for taking:

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I assume responsibilities for fees associated with those procedures>

Patient's (Parents) Signature _____ Date _____

