Date _____ **Patient Information** Patient # _____

Name					
Name to be Called					
Address					
City			State		Zip
Home Phone No.			Cell No.		Employer
Birthdate	Age		Male	Female	Business Address
Married	Single		Divorced	Widowed	City
SS No.			E-Mail		Business Phone No. Ext.
Previous Dentist				Physician	
Referred to us by:				What is purpose of this visit:	
Closest relative not living with you:					
Address				Phone No.	
Spouse Information					
Name					
Occupation				Employer	
Business Address				City	
Business Phone No.				Ext.	

Person Financially Responsible for Account (if not Patient)

Name			
SS#	Birthdate	Occupation	Employer
Business Address	City		
Business Phone No.	Ext.		

DENTAL INSURANCE

Insurance Company	Group Number
Employee	DOB
Employee SS#	
Employer	
Business Address	
Business Phone # Ext.	

SECONDARY INSURANCE

Insurance Company	Group Number
Employee	DOB
Employee SS#	
Employer	
Business Address	
Business Phone # Ext.	

MEDICAL HISTORY

Patient Name _____ Medical Alert _____

1. Have you ever been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Are you taking any medication or drugs? ☐ Yes ☐ No
   If yes, please list name and dosage. _____
3. Are you aware of having an allergic (or adverse reaction) to any medication or anesthesia? ☐ Yes ☐ No
   If yes, please list? _____
4. Have you been hospitalized in the last five years? ☐ Yes ☐ No
5. Indicate which of the following you have had, or have at the present. Check "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Radiation / Chemotherapy	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Required to Take Antibiotics Before Dental Treatment	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Sexually Transmitted Diseases	☐ Yes	☐ No
Artificial Joints (Hip, Knee, Etc.)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Cold Sores / Fever Blisters	☐ Yes	☐ No
Implants (Physical or Dental)	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Tobacco Use	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Nervous / Anxious	☐ Yes	☐ No

6. Do you take or have you ever taken bone density medications such as ☐ Yes ☐ No
   Fosamax, Boniva, Actonel, Zometa, Aredia, etc.? _____
7. Are you currently taking a daily Aspirin regimen? ☐ Yes ☐ No
   If yes, please describe? _____
8. Do you have or had any disease, condition, or problem not listed? ☐ Yes ☐ No
   If yes, please list? _____
9. Women are you: Pregnant? Yes,____ Month _____ No ____

History Review .....Date _____ Date _____ Date _____ Date _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Interest will be charged on account after 30 days. I understand that after 60 days, I am responsible for all charges regardless of whether or not my insurance reimbursement has been received.

Patient / Guardian Signature _____ Date _____

Carolina Smiles, LLC

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(864) 583-3717 • Fax: (864) 573-6067

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____