

Personal Information

Patient Full Name _____ Preferred Name _____ Birth Date _____
 Mother's Full Name _____ Father's Full Name _____
 Home # () _____ Parent Cell # () _____ Mother/Father please circle one
 Home Address _____ City _____ State _____ Zip _____
 Hobbies/Interest _____ Referred by _____

Medical Information

- 1. Are you presently under the care of a physician? Yes No
- 2. Have you ever had high blood pressure? Yes No
- 3. Has a physician ever said you have heart trouble? Yes No
- 4. Do you have Artificial Joints?.....When _____ Yes No
- 5. Have you ever had abnormal bleeding following a cut or extraction? Yes No
- 6. Have you ever had an anesthetic (either local or general)? Yes No
- 7. Has a physician or dentist ever said you have a tumor or cancer? Yes No
- 8. Are you allergic to Penicillin, Novocain, Codeine or any other medication? Yes No
 If so, What? _____
- 9. Are you allergic to anything other than medication? (e.g. latex or metals) Yes No
 If so, What? _____

Do you take or have you taken any Bisphosphonates listed (circle):
 Fosamax Actonel
 Didronel Actonel with Calcuim
 Boniva Reclast

Do you have or have ever had:

- 1. Rheumatic Fever Yes No
- 2. Rheumatic Heart Disease Yes No
- 3. Congenital Heart Disease Yes No
- 4. Leukemia Yes No
- 5. Low platelets Yes No
- 6. Tuberculosis Yes No
- 7. Diabetes?(circle one) Type 1 Type 2 Yes No
- 8. Blood Disorder Yes No
- 9. Liver Trouble or Jaundice Yes No
- 10. Epilepsy or Convulsions Yes No
- 11. Heart Murmur Yes No
- 12. Hepatitis Yes No
- 13. Eczema or Hives Yes No
- 14. Asthma or Hay Fever Yes No

Are you now taking:

- 1. Drugs for high blood pressure Yes No
- 2. Drugs for Sleep Yes No
- 3. Cortisone, Steroids or ACTH Yes No
- 4. Anticoagulants or blood thinner Yes No
- 5. Tranquilizers or sedatives Yes No
- 6. Antibiotics Yes No
- 7. Insulin Yes No

Have you had Dental Treatment in the past?
 ___ None ___ Emergency Only
 ___ Regular ___ First Visit

Have you ever been under the care of a physician for any major illness or injury, not listed above? (Please note) _____

 Please list treating Medical Doctor that you are currently under their care
 For what? What City/State are they located? _____

Account/Insurance Information

Person Responsible for Account _____ Relationship to Patient _____
 Insurance Holder's Name _____ Sex ___ DOB _____ SS# _____
 Insurance Holder's Employment _____ Insurance Company Name _____
 Any #'s that me be required (such as: Member I.D. Group#, ect.) _____

Additional Insurance Coverage:

Person Responsible for Account _____ Relationship to Patient _____
 Insurance Holder's Name _____ Sex ___ DOB _____ SS# _____
 Insurance Holder's Employment _____ Insurance Company Name _____
 Any #'s that me be required (such as: Member I.D. Group#, ect.) _____

I verify that the preceding information is true. I authorize the release of information to my insurance company. I authorize release of any information relating to my claim. I authorize payment directly to Southern Comfort Dental. I understand all fees not paid by my insurance company is my responsibility. I will allow the Doctors and Staff of Southern Comfort to discuss my conditions with my physician(s) and to request medical information from them. I authorize the office of Southern Comfort Dental to obtain and verify a credit report, if credit is extended to my account. I also acknowledge that I have been given or offered a copy of the of office's "Notice of Privacy Practices."

Signature _____ Date _____