Welcome

Todd A. Carter, D.D.S., Inc.

Date _____

Home Phone # _____

Cell Phone # _____

Driver's License or
Social Security # _____

Patient Information (CONFIDENTIAL)

Name _____ Nickname: _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Boxes: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Male ☐ Female

Employer/School _____ Contact # _____

Spouse or Parent's Name _____ Contact # _____

Emergency Contact (Relationship) _____ Contact # _____

Whom May We Thank for Referring You? _____

Responsible Party ☐ Same as Above ☐ Other - Please complete section below

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Contact # _____

Driver's License or Social Security # _____ Birthdate _____

Employer _____ Contact # _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name Of Employer _____ Work Phone _____

Insurance Company _____ Policy/ID # _____ Group # _____

Ins. Company Address _____ City _____ State _____ Zip _____

Medications

List any medications you are currently taking:
*Or we would gladly copy a list

_____

_____

_____

_____

_____

_____

_____

Allergies ☐ None

Check (✔) if you are allergic to or have had any reactions to the following:

☐ Local Anesthetics (eg. Novocaine)

☐ Penicillin (or other Antibiotic - List Separately)

_____

☐ Sulfa Drugs ☐ Latex Rubber

☐ Barbiturates ☐ Sedatives

☐ Iodine ☐ Aspirin ☐ Codeine

☐ Any Metals (eg. Nickel, Mercury, etc.)

Other: _____

Patient Medical History

Name _____ Date _____

Physician _____ Date of Last Exam _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If Yes, please describe _____

_____

Does your physician require you to take special medication(s) before dentistry? If so, what? _____

Are you now or have you ever taken drugs for Osteoporosis? ☐ Yes ☐ No If yes, for how long? _____

Do you take a blood thinner? ☐ Yes ☐ No Are you under any medical treatment now? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, what type? _____ How Often? _____

Check (✔) if you have or have had in the past any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
  Location: _____
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
  Type: _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes Type:_____
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hayfever/Allergies
- ☐ Headaches
- ☐ Hearing Aids
- ☐ Heart Murmur
- ☐ Heart Problems (describe)
  _____
  _____
- ☐ Hemophilia
- ☐ Hepatitis Type:_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Parkinson's
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath/COPD
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vertigo
- ☐ Yellow Jaundice
- ☐ Other: _____
  _____

Women:
Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control? ☐ Yes ☐ No

Patient Dental History

Physician _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No
4. Do you feel pain in any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Have you ever experienced any of the following problems in your jaw:
   - Clicking ☐ Yes ☐ No
   - Pain (joint, ear, side of face) ☐ Yes ☐ No
   - Difficulty in opening or closing ☐ Yes ☐ No
   - Difficulty in chewing ☐ Yes ☐ No
8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
11. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
12. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No
13. Have you had any orthodontic treatment? ☐ Yes ☐ No
14. Do you wear dentures or partials? ☐ Yes ☐ No
15. Do you have any dental implants? ☐ Yes ☐ No
16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No
17. Have you had wisdom teeth extracted? ☐ Yes ☐ No

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 my 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 payors 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.

X _____ Date _____

Signature of patient (or parent if minor)