

JAMES W. DENNY, DMD
COSMETIC AND RESTORATIVE DENTISTY
1197-B NORTH LAKE DRIVE
LEXINGTON, SOUTH CAROLINA 29072
TELEPHONE (803) 358-2211

Welcome to our Family Practice. We consider this a privilege and honor to allow us to care for your dental needs. Our staff is committed to serve you in the most professional manner. To insure that your health is safe guarded to the utmost, we ask that you complete the following questionnaire as accurately as possible. Rest assured this information is held in strict medical confidence.

DATE _____

PERSON RESPONSIBLE FOR ACCOUNT

LAST FIRST M

ADDRESS: OF ACCOUNT HOLDER: _____
STREET APT.# CITY STATE ZIP

PHONE #'S OF ACCOUNT HOLDER: _____
HOME WORK EXT.

If you (the patient), have Dental insurance, give the name of the person who is the policy holder _____

Relationship of insured to patient: ☐ Self ☐ Father ☐ Mother ☐ Spouse

SS# of policyholder _____ Birthdate of policyholder _____

Place of Employment of policyholder _____

Name of Dental Insurance Company _____ Group # _____

Address of Insurance Co. _____
STREET APT.# CITY STATE ZIP

Phone # of Insurance Co. _____ Work Address of Policy Holder _____
CITY STATE

PATIENT INFORMATION

Name of Patient _____
LAST FIRST MIDDLE

Patient Address _____
(If Different from Account Holder) _____
STREET APT.# CITY STATE ZIP

Phone #'s _____
HOME WORK EXT.

SS # _____ Birthdate _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Medical Alert for Patient

Person to Contact In Case Of Emergency _____ Daytime Phone # _____

Whom may we thank for referring you to our office? _____

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X _____
☐ Adult Patient ☐ Father ☐ Mother ☐ Guardian
STATE DRIVER'S LICENSE NUMBER _____
DATE _____

See Reverse Side

PATIENT INFORMATION

SECONDARY INSURANCE IS FILED BY PATIENT. PLEASE ASK FOR INSURANCE RECEIPT.

PATIENT NAME _____ DATE _____

LAST

FIRST

M

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe _____
Do you have dental examinations on a routine basis? Last visit _____
Would you describe your present dental health as good? Comments _____
Do you think you have active decay or gum disease? _____
Do your gums ever bleed? Discuss _____
Do you brush and floss on a routine basis? Discuss _____
Do you feel nervous about having dental treatment? _____
Have you ever had a bad experience in a dental office? Describe _____
Do you want to keep your remaining teeth? _____
Do you like your smile? Why? _____
Name of previous dentist (optional) _____
Do you ever brux or grind your teeth? Discuss _____
Have you ever had orthodontic treatment (tooth straightening)? _____
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss _____

PLEASE CIRCLE

YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO
YES NO

MEDICAL HISTORY

Medical doctor's name _____
Are you under a doctor's care now? Why? _____
Have you been hospitalized or received a blood transfusion? When? _____
Are you taking any medications, pills, or drugs? What? _____
Are you allergic to any medications or substance? What? _____
Are you pregnant? (women) _____

YES NO
YES NO
YES NO
YES NO
YES NO

Please CIRCLE if you have had any of the following:

Heart Trouble
High Blood Pressure
Low Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesion
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Blood Disease
Anemia

Chest Pain
Shortness of Breath
Swelling of Feet/Ankles/Hands
Fainting or Dizziness
Stroke
Diabetes
Excessive Thirst
Artificial Joints/Hips
Kidney Trouble
Ulcers
Allergies

Scarlet Fever
Asthma
Hay Fever
Sinus Trouble
Emphysema
Frequent Cough
Lung Disease
Tuberculosis
Liver Disease
Hepatitis A (infect.)
Hepatitis B (serum)
Yellow Jaundice
Recent Weight Loss

Cancer
Thyroid Disease
Parathyroid Disease
X-ray or Cobalt Tmt.
Chemotherapy/Radiation
Arthritis/Gout
Rheumatism
Pain in Jaw Joints
Cortisone Medicine
Glaucoma
Epilepsy or Seizures
Nervousness
Alzheimer's Disease

Hypoglycemia
Psychiatric Care
Drug Addiction
Blood Transfusion
Hemophilia
AIDS (HIV)
Venereal Disease
Cold Sores
Fever Blisters
Herpes
Bruise Easily
Sickle Cell Anemia

Have you ever had any other serious illness not circled above? _____
Please describe in detail _____
Do you wish to talk to the doctor privately about any problem? _____

☐ YES ☐ NO
☐ YES ☐ NO

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____