Ashley Dental Associates, PA

Cosmetic & Family Dentistry

www.ashleydentalcharleston.com

Welcome to our Practice!

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____ Preferred Name_____
Date of Birth_____ Age_____ Sex_____ Height _____ Weight_____
Mailing Address_____City_____State_____Zip_____
Home Phone_____ Work Phone _____ Cell_____
Employer_____Occupation_____
SS#_____ Drivers License #_____Email _____
Marital Status: ____Married _____Divorced _____Single _____Widowed ____Separated
If Married: Name of Spouse _____ Date of Birth _____ SS# _____
Employer_____Occupation_____Work Phone_____
How were you referred to our office? _____

COMPLETE BELOW IF PATIENT IS A MINOR

Father's Name _____ SS#_____ Date of Birth _____
Employer _____Work phone _____ Cell Phone_____
Mother's Name _____ SS#_____ Date of Birth _____
Employer _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Carrier _____Phone Number _____
Insured Name _____ SS# _____
Employer _____ Date of Birth _____
Secondary Insurance Carrier _____Phone Number _____
Insured Name _____ SS# _____
Employer _____ Date of Birth _____

MEDICAL HISTORY

Do you have any of the following medical conditions? Check ONLY those that apply.

	Heart Condition/murmur		Pins, plates, screws		Nervous problems		Recent Weight Loss
	Artificial valve/joint		Respiratory disease/Asthma		Psychiatric problems		AIDS/HIV positive
	Rheumatic/Scarlet fever		Shortness of breath		Sleep Apnea		Hepatitis
	Mitral Valve Prolapse		Panic attacks		Chemical dependency		Kidney/liver disease
	Congenital heart disease		Sinus Problems		Anemia/Hemophilia		Yellow Jaundice
	High blood pressure		Thyroid problems		Blood disease		Venereal disease
	Chest pain/ strokes		Ulcer/stomach issues		Blood Transfusion		Epilepsy/seizers
	Dizzy spells, fainting		Depression		Bleeding Problems		Diabetes

Are you allergic to any of the following: Check ONLY those that apply.
____ Latex ____ Penicillin ____ Local Anesthetic ____ Sulfa ____Codeine ____Aspirin _____Others

Do you have any condition or disease not listed above? _____
Are you under the care of a physician? _____ Dr. Name _____

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