# BRUNSWICK FAMILY DENTISTRY

Parent or Guardian's Name (If under age 18):______________________________ Today's Date:__________

Last Name:____________________ First Name:______________________ MI:_____ SSN#:__________

Preferred Name:______________________________ Gender: ☐ M ☐ F Birth Date:__________ Age:______

Mailing Address ____________________________________ City __________ State_____ Zip__________

Employer:____________________ Emergency Contact Info:______________________________

Home Phone __________ Cell__________ Work__________ Email______________________

How did you hear about our office? ________________________________________

If you require a referral, which general location do you prefer?: ☐Wilmington (North) North Myrtle Beach (South)

## PAST MEDICAL / DENTAL HISTORY

Previous Dentists______________________________ Phone #__________ Last Visit Date: __________

Primary Physician______________________________ Phone # __________ Last Visit Date: __________

Serious illnesses or surgeries in previous five years? Please describe:______________________________

Women: Are you pregnant? ☐ Y ☐ N How many weeks?_____ Ob/Gyn?__________ Nursing? ☐Y ☐N BCP? ☐Y ☐N

**The following information is essential to provide dental as a part of your overall health. Incorrect or incomplete information may be harmful to you. Please ask a staff member if you need assistance with any questions.**

**Are you allergic to, or have you had an adverse reaction to, any of the following medications?**

☐ Aspirin ☐NSAIDS ☐ Penicillin ☐ Clindamycin ☐ Sulfa ☐Codiene

☐ Hydrocodone ☐Oxycodone ☐ Other__________ If yes, please describe______________________

**Latex Allergy?** ☐ Y ☐ N

**Have you ever had an adverse reaction to dental anesthetics?** ☐ Y ☐ N

If yes, please describe________________________________________

**Do you have a medical condition that requires antibiotics before dental treatment?** (SBE Prophylaxis) ☐ Y ☐ N

If yes, please describe: ______________________________ Antibiotic used?:__________

**Please list any medications you are currently taking:**

| Name: | Dosage: | Reason for taking: |
|---|---|---|
| ____________ | ________ | ____________ |
| ____________ | ________ | ____________ |
| ____________ | ________ | ____________ |
| ____________ | ________ | ____________ |
| ____________ | ________ | ____________ |

Pharmacy Name: ______________ Pharmacy Phone: ______________

**Do you take any blood thinners, including aspirin?** ☐ Y ☐ N If yes, please specify____________________

**Do you have or have you had any of the following?**

**Heart Problems?** ☐ Y ☐ N ☐ High Blood Pressure ☐Angina ☐Heart Defect ☐Artificial heart valve

☐ Pacemaker ☐ Stroke (Date)__________ ☐Heart Attack (Date)__________

☐ Cardiovascular disease (Specify)________________________________________

**Respiratory Problems?** ☐ Y ☐ N ☐ Asthma ☐COPD ☐ Emphysema ☐COPD ☐Other__________

☐ Tuberculosis (Date)__________ Do you use Oxygen? ☐ Y ☐ N

**Kidney Problems?** ☐ Y ☐ N ☐ Dialysis? ☐ Y ☐ N Days of the week?:____________________

**Liver Problems?** ☐ Y ☐ N ☐ Hepatitis ? ☐ Y ☐ N If yes, which type? ____________________

**Artificial Joint?** ☐ Y ☐ N Type______________ If yes, give date(s)________________ SBE Prophylaxis ☐ Y ☐ N

**Cancer?** ☐ Y ☐ N Type________________________________________ Year diagnosed? ______________
Chemotherapy? ☐ Y ☐ N Radiation therapy? ☐ Y ☐ N

**Diabetes / High Blood Sugar?** ☐ Y ☐ N Do you use insulin? ☐ Y ☐ N

**Epilepsy / Seizures?** ☐ Y ☐ N If yes, date of last seizure______________ Type______________Duration__________

**HIV+ / AIDS?** ☐ Y ☐ N If yes, year of diagnosis__________________ Most recent T-cell count ______________

**Sexually Transmitted Disease?** ☐ Y ☐ N ____________________________

**Blood Disorder?** ☐ Y ☐N ☐ Hemophilia ☐ Sickle Cell Anemia ☐ Sickle Cell Trait ☐Other____________

**Back / Neck Surgery?** ☐ Y ☐ N If yes, give date(s) ______________________________

**Eating Disorder?** ☐ Y ☐ N ________________________________________

**Developmental Disability?** ☐ Y ☐ N
☐ Intellectual Disability ☐ Autism ☐ ADD/ADHD ☐ Other__________________________

**Mental Illness?** ☐ Y ☐ N
☐ Schizophrenia ☐ Dementia ☐ Bipolar ☐Anxiety ☐ Other __________________________

**Physical Disability?** ☐ Y ☐ N Are you in a wheelchair? ☐ Y ☐ N
If yes, please specify:____________________________________________________________

**Do you smoke?** ☐ Y ☐ N Smokeless/Chewing Tobacco? ☐ Y ☐ N
How much?____________________________ How Often?__________________________________________

**Why have you come to the dentist today?**__________________________________________________

**AUTHORIZATION:**
**- I have received, read and understand the Notice of Privacy Practices (HIPAA).**
**- I authorize my insurance company to pay this dental practice all benefits for services rendered.**
**- I authorize use of this signature on all insurance submissions.**
**- I authorize the dentist to release all information necessary to secure the payment of benefits.**

**Preferred method of contact for appointment confirmation.**
Please note, checking multiple options will result in automatic reminders sent to each item given. You will have the option to change the reminder status when they are received. When sharing an email address or phone number with multiple family members a reminder is automatically sent for each family member with appointments on the same day as opposed to just one per family. It is simply a limitation of the computer software not an intentional choice on our part. We apologize for any inconvenience this may cause.

☐Home Telephone ☐ Mobile Telephone ☐ Text Message ☐Email ☐Other:____________________

__________________________________________ ______________________________________
Signature of patient or legal guardian Date

Thank you for choosing to join our dental family. Our goal is always to provide care in a safe, friendly environment.