Lowcountry Periodontics & Dental Implants

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(843) 208-2222 Fax (843) 208-2236

Date _____

Patient Name _____ SS#_____

Patient Address _____ Date of Birth _____ Age _____

City, State, Zip _____ Marital Status _____ Sex _____

Home Phone _____ Work Phone _____ Cell _____

Email Address_____

Place of Employment _____ Occupation _____

Person Responsible for Account _____

Do You Have *Dental* Insurance? □ Yes □ No

Policy Holder Information: Name _____ Date of Birth _____ SSN# _____

Insurance Company Name _____ Policy #_____

Do You Have Secondary *Dental* Insurance? □ Yes □ No Name of Insured _____

Insurance Company Name _____ Policy # _____

In Case of Emergency Call _____ Phone #_____

Who Referred You To Our Office? _____

Is Any Member of Your Immediate Family a Patient Here? □ Yes □ No Name_____

I, the undersigned patient or legally responsible party, authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances and accounts over 60 days will be charged a finance charge of 1.5% per month (18% annually), on any unpaid balance. The cost incurred in collecting this account, including court costs, agency fees and attorney fees will be added to the balance due. I acknowledge that in keeping with the Health Insurance Portability & Accountability Act of 1996 (HIPPA), the release of health care records can be done for the purposes of treatment, payment, or health care operations. I have been given the opportunity to review this office's "Notice of Privacy Practices" and also assign to the doctor all insurance payments, should claims be filed as assigned benefits.

Signature of Person Responsible for Account _____

1. **Please list all medication(s) that you are currently taking, including aspirin**: _____

_____

2. Are you under any medical treatment now? If so, what? _____
3. Have you had any major operations? If so, what? _____
4. Has a physician ever informed you that you had:

CARDIOVASCULAR	**YES**	**NO**
Rheumatic Fever	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Murmurs	☐	☐
Congenital Heart Defect	☐	☐
Angina or Heart Attack	☐	☐
Stroke	☐	☐
Congestive Heart Failure	☐	☐
Heart Surgery	☐	☐
Pacemaker	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
RESPIRATORY DISEASE		
Asthma	☐	☐
Emphysema	☐	☐
Seasonal Allergies	☐	☐
Shortness of Breath	☐	☐
INFECTIOUS DISEASES		
Hepatitis	☐	☐
Tuberculosis	☐	☐
HIV Positive	☐	☐

KIDNEY DISEASE	**YES**	**NO**
Have you had any kidney infections?	☐	☐
Are you presently on Dialysis	☐	☐
ENDOCRINE DISORDERS		
Diabetes	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
MISCELLANEOUS DISEASES & DISORDERS		
Frequent Fainting	☐	☐
Liver Disease	☐	☐
Arthritis	☐	☐
Glaucoma	☐	☐
Cancer	☐	☐
Radiation Therapy for Cancer	☐	☐
Epilepsy (Seizures)	☐	☐
Psychiatric Treatment	☐	☐
Do you Smoke?	☐	☐
Do your ankles swell?	☐	☐
Do you have to sleep inclined?	☐	☐
BLOOD DISORDERS		
Anemia	☐	☐
Do you bleed excessively when cut?	☐	☐
Leukemia	☐	☐

	YES	**NO**
Are you in general good health at this time? _____	☐	☐
Have any wounds healed slowly or presented other complications?_____	☐	☐
Do you have a history of fainting or seizures? _____	☐	☐
Have you had joint replacement surgery? _____	☐	☐
Do you have a history of drug or alcohol abuse? _____	☐	☐
Do you habitually clench your teeth during the day or night? _____	☐	☐
Do you have jaw joint problems such as clicking, locking or pain? ____	☐	☐
Are you allergic to, or have you ever reacted adversely to:		
Local anesthetic (such as Novocain)? _____	☐	☐
Penicillin, sulfa drugs, or other antibiotics? _____	☐	☐
Aspirin or codeine?_____	☐	☐

Latex, or any other allergies not listed?_____

Are there any medical or dental conditions you feel your dentist should know before undertaking dental treatment?
If so, explain?_____

Have you ever taken or had administered, Zometa, Fosamax, Aredia, Actonel, Boniva, Prolia or Reclast (circle any that apply)

WOMEN	**YES**	**NO**
Are you pregnant? _____	☐	☐
Are you nursing? _____	☐	☐
Are you taking birth control pills? _____	☐	☐

I certify that I have read and understand the above; I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors of omissions that I may have made in the completion of this form.

_____ _____

Patient's Signature Date Doctor's Signature Date