LOWCOUNTRY ENDODONTICS OF BEAUFORT, LLC

Mr., Mrs., Dr., Ms._____Date of Birth_____/_____/_____

Mailing Address _____
Street City Zip Code

Home Phone:_____ Business Phone:_____ Cell Phone:_____

Email address_____

Patient Employed by: _____Business Address:_____

Occupation:_____Social Security No:_____

Name of spouse, parent or nearest relative: _____

Employer: _____ Cell Phone: _____

If patient is a minor, who is legally responsible? _____Relationship to patient: _____

Referring Dentist: _____Family Physician: _____

HEALTH HISTORY YES NO

1. Are you currently under the care of a physician? If yes, what for? _____ ☐ ☐
   _____
2. Are you allergic or sensitive to Novocaine, Penicillin, Sulfa, Codeine, Aspirin, or any other drug or medication? If so, what? _____ ☐ ☐
   _____
3. Are you taking any medication, drug, or vitamin now? Please list_____ ☐ ☐
   _____
4. Have you received or are you currently taking Fosamax, Actonel, Zometa, Aredia or Boniva? ☐ ☐
   _____
5. Have you had or do you have any of the following? Please circle, if yes.

Heart trouble	Pacemaker	Latex allergy	Glaucoma
Heart murmur	Kidney trouble	Diabetes	Addiction
Mitral valve prolapse	Anemia/blood disorders	Ulcer	Emotional disorders
Heart surgery/Valve	Excessive bleeding	Thyroid disease	Epilepsy
Rheumatic heart fever	Stroke	Liver disease (jaundice)	Asthma/allergies
Irregular heart beat	High blood pressure	Hepatitis	AIDS/HIV positive

Artificial joint? (location) _____Date Placed?_____

6. Have you had any other serious illness? Yes ☐ No ☐ If so what?_____

7. Female Patients: Are you pregnant? _____Which month? _____
   Are you nursing? _____Taking birth control pills? _____

Total payment of the dental service is the responsibility of the patient and not that of the insurance company. We will be happy to complete your insurance form so that your insurance company may reimburse you. Is the treatment partly covered by dental insurance? _____Name of Company_____

Method of payment: Check __ Cash __ Visa __ Mastercard __ Amex __ Discover __ Care Credit ___

Patient's/Parent's Signature: _____Date: _____/_____/____