Lowcountry Family & Cosmetic Dentistry

868 Savannah Highway
Charleston, SC 29407
(843) 766-7713

Name _____ Employer _____
Address _____ Address _____
City & Zip _____ City & Zip _____
Home Telephone _____ Work Telephone _____
Age _____ Birth Date _____ Name of Insured _____
SS# _____ Relation to Patient _____
Sex _____ Marital Status _____ Birth Date _____ SS# _____
Spouse / Parent _____ Insurance Co. _____ Group # _____
Physician _____ Insurance Co. Address _____
In Case of Emergency (Closet Relative or Friend) _____ Referred By : _____
Phone Number _____ How long since last dental check-up ? _____

Confidential Medical History

1. The reason for your dental visit _____ (Circle)
2. Are you having pain or discomfort at this time? YES NO
3. Do you feel very nervous about having dental treatment? YES NO
4. Have you ever had a bad experience in the dentist's office ? YES NO
5. Have you ever been a patient in the hospital during the past two years ? YES NO
6. Have you been under the care of a medical doctor during the past two years ? YES NO
7. Have you taken any medicine or drugs during the past two years ? YES NO
8. Are you allergic to (i.e. itching, rash, swelling of hands , feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs or medication ? YES NO
9. Have you had any excessive bleeding requiring special treatment ? YES NO
10. Circle any of the following which you have had or have at present :

Allergies or Hives	Cough	Heart Murmur	Rheumatic Fever
Anemia	Cortisone Medicine	Heart Pacemaker	Rheumatism
Angina Pectoris	Chemotheraphy, Leukemia	Heart Surgery	Scarlet Fever
Artificial Heart Value	Drug Addiction	Hemophilia	Sickle Cell Disease
Artificial Joint	Diabetes	Hepatitis A (infectious)	Sinus Trouble
Arthritis	Emphysema	Hepatitis B (serum)	Stroke
Asthma	Epilepsy or Seizures	High Blood Pressure	Thyroid Disease
Aids	Fainting or Dizzy Spells	Kidney Trouble	Tuberculosis
Blood Transfusion	Glaucoma	Liver Disease	Ulcers
Bruise Easily	Hay Fever	Nervousness	Venereal Disease (Syphilis, Gonorrhea)
Cold Sores	Heart Disease or Attack	Pain in Jaw Joint	X-ray Treatment
Congenital Heart Lesions	Heart Failure	Psychiatric Treatment	Yellow Jaundice

11. Do you grind or clench your teeth ? YES NO
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired ? YES NO
13. Do your ankles swell during the day ? YES NO
14. Have you lost or gained more than 10 pounds in the last year ? YES NO
15. Do you ever wake up from sleep short of breath ? YES NO
16. Are you on a special diet ? YES NO
17. Has your medical doctor ever said you have cancer or a tumor ? YES NO
18. Do you have any disease, condition, or problem not listed ? YES NO
19. WOMEN : Are you pregnant now ? YES NO
    Are you practicing birth control ? YES NO
    Do you anticipate becoming pregnant ? YES NO

This is to certify that I, the undersigned, consent to the performing of dental and oral surgery procedures to be necessary or advisable including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment, without fail.

I hereby authorize that as long as Brooke N. Bode, D.M.D. keeps this document on file, she may use it to represent my consent in filing for insurance payment of any dental procedures she has performed for myself or my dependents. Payment of insurance benefits otherwise payable to me will be made directly to Brooke N. Bode, D.M.D. I authorize the release of any information relating to these claims. I understand that I am responsible to pay for services rendered, including costs for collection in the event of non-payment.

SIGNATURE _____ DATE _____