Solomon Family Dentistry
1971 N. Main Street
Summerville, SC 29483
843-871-0842

Patient Name:_____

Sex: M F Age: Birthdate:____/_____/_____ SS#_____

Marital Status:_____

Email:_____

Mailing Address:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ (Can you receive calls here?) *Yes* *No*

In case of Emergency Contact:_____

Phone number:_____

Relation to the Patient:_____

Insured's Employer:_____

Insurance Carrier:_____

Physician's Name/Phone Number:_____

YES NO 1. Has there been any change in your general health within the past year?
2. My last physical examination was on _____
YES NO 3. Are you now under the care of a physician?
a. If so, what is the condition being treated?_____
YES NO 4. Have you had any serious illness or operation?
a. If so, what was the illness or operation?
_____
YES NO 5. Have you been hospitalized or had a serious illness within the past five (5) years?
a. If so, what was the problem?
_____
YES NO 6. Have you been involved in an accident in the last five years?
YES NO 7. Do you have or have you had any of the following disease or problems:
YES NO a. Rheumatic fever or rheumatic heart disease?
YES NO b. Recurrent sore throats?
YES NO c. Congenial heart lesions.
YES NO d. Cardiovascular disease? (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
YES NO (1) Do you have chest pain upon exertion?
YES NO (2) Are you ever short of breath after mild exercise?
YES NO (3) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?
YES NO e. Do you have a cardiac prosthesis (artificial valve)?
YES NO 8. Do you use: Tobacco?
Pipe ____; Cigars ____; Snuff ____;

YES NO 9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
YES NO a. Do you bruise easily?
YES NO b. Have you ever required a blood transfusion? Please explain_____
_____
YES NO 10. Do you have any blood disorders such as anemia?
YES NO 11. Have you had surgery or x-ray treatment for a tumor, growth or other condition?
12. Are you taking any of the following:
YES NO a. Antibiotics or sulfa drugs?
YES NO b. Anticoagulants (blood thinners)
YES NO c. Medicine for high blood pressure
YES NO d. Cortisone (steroids)
YES NO e. Tranquilizers
YES NO f. Antihistamines
YES NO g. Aspirin
YES NO h. Insulin, tolbutamide (Orinase) or similar drug
YES NO i. Thyroid medication
YES NO j. Digitalis
YES NO k. Nitroglycerin
YES NO l. Other drugs for heart condition
YES NO m. Weight control medicine
YES NO n. Other
13. Are you allergic or have you reacted adversely to:
YES NO a. Local Anesthetics
YES NO b. Penicillin or other antibiotics
YES NO c. Sulfa Drugs
YES NO d. Barbituates, sedatives or sleeping pills
YES NO e. Aspirin
YES NO f. Iodine
YES NO g. Other_____
YES NO 14. Are you pregnant?
YES NO 15. Have you ever been tested for and found positive for HIV/AIDS?

Dental History

Do you favor one side? Y N If yes, which side?_____
Do you clench or grind your teeth? Y N
Do you have any gum swelling around any teeth? Y N
Have you had any previous injuries to the face or jaw? Y N
Have you ever had periodontal (gum) surgery? Y N
Have you ever had a bad dental experience? Y N
Has the fear of discomfort kept you from seeking dental care Y N

Consent for Procedure

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedure agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature_____Date_____
Remarks: