Folly Beach Family Dentistry

REGISTRATION & HEALTH HISTORY

Patient's name: _____ Preferred Name: _____ Date: _____
Last, First, Middle Initial

Mailing address_____ Street Address (if different): _____

City: _____ State: _____ Zip: _____ SS# _____

Date of Birth: _____ Sex: ☐ M ☐ F ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Email address: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Employer or School: _____ Occupation: _____

Spouse:_____ Date of Birth: _____ Cell phone: _____

Spouse's Employer: _____ Occupation: _____

Who may we thank for referring you to our practice/How did you hear about us? _____

IN CASE OF EMERGENCY CONTACT (please specify someone who does not live in your household):

Name: _____ Relationship: _____ Cell phone: _____ Other: _____

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to patient? _____

Subscriber's Name: _____ Date of Birth: _____ ID# _____

Dental Insurance Company: _____ Group Number: _____

Is patient covered by additional insurance? ☐ Y ☐ N If yes, Subscriber Name: _____

DOB: _____ SS/ID# _____ Insurance Co: _____ Group #: _____ Relationship: _____

I certify that I, and/or my dependent(s) have insurance coverage with the above mentioned carrier and assign directly to Folly Beach Family Dentistry all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above named practice may use my health care information and may disclose such information to the above named insurance carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ Date:_____
Print name *Signature*

DENTAL HISTORY

Purpose of today's visit: _____ Former Dentist: _____ City/State: _____

How often do you floss? _____ How often do you brush? _____ Is there anything you'd like to change about the color or appearance? _____

Check all that apply:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Cigarette, pipe, cigar or vaping
- ❑ Clicking or popping jaw
- ❑ Dry mouth
- ❑ Fingernail biting
- ❑ Food collection between teeth
- ❑ Foreign objects
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tiredness
- ❑ Lip or cheek biting
- ❑ Loose teeth or broken filling(s)
- ❑ Mouth breathing
- ❑ Mouth pain to brushing
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth