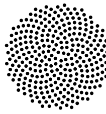

Dan L. Perry, Jr., D.M.D.
SPRING HILL COMPREHENSIVE DENTISTRY PC
www.shcdentistry.com
251.343.1559

Today's Date: ______________________

Name: ______________________

I Prefer to be Called: ______________________

Home Address: ______________________

Home Phone: ______________________

Work Phone: __________ Ext: __________

E-mail Address: ______________________

Social Security Number: ______________________

Birthdate: ______________________

Single Married Divorced Widowed Separated

Male Female

Referral Source: ______________________

Previous Dentist: ______________________

Last Visit Date: ______________________

Employer: ______________________

Occupation: ______________________

Employer's Address: ______________________

____

SPOUSE OR SIGNIFICANT OTHER INFORMATION (if applicable)

Spouse's Name: ______________________

Spouse's Employer: ______________________

Work Phone: __________ Ext: __________

Spouse's SS#: ______________________

Spouse's Birthdate: ______________________

ACCOUNT INFORMATION

Person Responsible for Account: ______________________

Relation: __________ S.S.# __________

Home Phone: __________

Work Phone: __________ Ext: __________

Billing Address: ______________________

____

Employer: ______________________

Fill in below if you need our assistance in maximizing your insurance benefits.

PRIMARY DENTAL INSURANCE (if applicable)

Insurance Company Name: ______________________

Phone Number: ______________________

Insurance Company Address: ______________________

Group Number: ______________________

Insured's Name: ______________________

Relation: ______________________

Insured's Birthdate: ______________________

Insured's Insurance ID Number: ______________________

Insured's SS#: ______________________

Insured's Employer: ______________________

SECONDARY DENTAL INSURANCE (if applicable)

Insurance Company Name: ______________________

Phone Number: ______________________

Insurance Company Address ______________________

Group Number: ______________________

Insured's Name: ______________________

Relation: ______________________

Insured's Birthdate: ______________________

Insured's SS#: ______________________

Insured's Employer: ______________________

MEDICAL INSURANCE (if applicable)

Insurance Company Name: ______________________

Phone Number: ______________________

Insurance Company Address ______________________

Group Number: ______________________

Insured's Name: ______________________

Relation: ______________________

Insured's Birthdate: ______________________

Insured's SS#: ______________________

Insured's Employer: ______________________

MEDICAL HISTORY

Your current physical health is: ❑Good ❑Fair ❑Poor

Are you currently under the care of a physician? ❑Yes ❑No

Please explain: ______________________________

Are you taking any prescription or over the counter drugs? Please list each one: ______________________________

____

____

Do you have a personal physician? ❑Yes ❑No

Physician's Name: ______________________________

Phone Number: ____________ Date of last visit: ________

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (circle)

Y	N	Asthma/Arthritis	Y	N	Kidney Problems
Y	N	Anemia/Radiation	Y	N	High/Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Severe/Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Shingles
Y	N	Diabetes	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	Stroke
Y	N	Drug/Alcohol Abuse	Y	N	Tuberculosis (TB)
Y	N	Emphysema	Y	N	Venereal Disease
Y	N	Epilepsy/Seizure	Y	N	Artificial Bone/Joints
Y	N	Fever Blisters/Herpes	Y	N	Artificial Valves
Y	N	Glaucoma	Y	N	Heart Attack
Y	N	Hemophilia/Abnormal Bleeding	Y	N	Heart Murmur
Y	N	Hepatitis	Y	N	Heart Surgery/Pacemaker
Y	N	HIV+/AIDS	Y	N	Mitral Valve Prolapse
Y	N	Hospitalized for any Reason	Y	N	Rheumatic/Scarlet Fever

Please list any other medical condition(s) that you have had:

____

____

Are you allergic to any of the following?

❑Aspirin ❑Latex

❑Codeine ❑Penicillin

❑Dental Anesthetics ❑Tetracycline

❑Erythromycin ❑Other__________________

FOR WOMEN:

Are you taking birth control pills? ❑Yes ❑No

Type of birth control: ______________________________

Are you pregnant? ❑Yes ❑No

Week #:______________________________

Are you nursing? ❑Yes ❑No

DENTAL HISTORY

Why have you come to the dentist today?

____

____

____

Are you currently in pain? ❑Yes ❑No

Have you ever had any serious/difficult problems associated with any previous dental work? ❑Yes ❑No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑Yes ❑No

Are you happy with your smile? ❑Yes ❑No

Do your gums ever bleed? ❑Yes ❑No

How many times a week do you floss? ________________

How many times a day do you brush? ________________

Have you had previous periodontal treatment? ❑Yes ❑No

If so, when and what? ______________________________

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name:________________ Relation: ____________

Work#: ________________ Home #: ____________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature (If patient is under 18, parent or guardian) Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

– OFFICE USE ONLY –

I have verbally reviewed the medical/dental information above with the patient named herein.

Signature: ______________________ Date: __________

Comments: ______________________________

Signature: ______________________ Date: __________

Comments: ______________________________

Signature: ______________________ Date: __________

Comments: ______________________________

Signature: ______________________ Date: __________

Comments: ______________________________

Signature: ______________________ Date: __________

Comments: ______________________________