JEFFREY LORCH, DMD
DEMPSEY BAILEY, DDS
A.W. TUCKER, DDS
SYLVAN VALLEY FAMILY DENTISTRY
134 South Johnson St. - Brevard, NC - 828-884-2144

*Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.*

Patient # _____

Date _____

## PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

E-mail _____ Cell #1 (____) _____ Cell #2 (____) _____

Employer _____ Employer Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse/Parents Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

Do you prefer your appointment confirmation by Text, Email or Phone? _____

## RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT INFORMATION)

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (_____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Currently a patient in our office? ☐ Y ☐ N E-mail _____ Cell # (____) _____

## DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# _____

Employer _____ Work Phone (_) _____

Employer/School Address _____ City _____ State _____ Zip _____

Insurance Company _____ ID # _____

Address _____ City _____ State _____ Zip _____

## DENTAL HISTORY

Check (✓) if you have had problems with any of the following:

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

### CONSENT TO TREATMENT

**I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History Form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that I will be informed of all possible complications of the procedures, anesthetics and/or drugs, before undergoing treatment.**

**"All services are rendered and accepted under the terms and conditions"**

**Signed:** _____ **Date** _____

**Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent**

**Relationship to Patient:** _____

Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body, Health problems the you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes _____

Do you take, or have taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Do you pre-medicate for dental work? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ Yes ☐ No If yes _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

Do you have, or have had, any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Hepatitis B or C | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Alzheimer's Disease | ☐ Yes ☐ No | Drug Addiction | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Rheumatism | ☐ Yes ☐ No |
| Anaphylaxis | ☐ Yes ☐ No | Easily Winded | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Shingles | ☐ Yes ☐ No |
| Angina | ☐ Yes ☐ No | Epilepsy or Seizures | ☐ Yes ☐ No | Hives or Rash | ☐ Yes ☐ No | Sickle Cell Disease | ☐ Yes ☐ No |
| Arthritis/Gout | ☐ Yes ☐ No | Excessive Bleeding | ☐ Yes ☐ No | Hypoglycemia | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Artifical Heart Valve | ☐ Yes ☐ No | Excessive Thirst | ☐ Yes ☐ No | Irregular Heartbeat | ☐ Yes ☐ No | Spina Bifida | ☐ Yes ☐ No |
| Artificial Joint | ☐ Yes ☐ No | Fainting Spells/Dizziness | ☐ Yes ☐ No | Kidney Problems | ☐ Yes ☐ No | Stomach/Intestinal Disease | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Frequent Cough | ☐ Yes ☐ No | Leukemia | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Frequent Diarrhea | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Swelling of Limbs | ☐ Yes ☐ No |
| Blood Transfusion | ☐ Yes ☐ No | Frequent Headaches | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Thyroid Disease | ☐ Yes ☐ No |
| Breathing Problems | ☐ Yes ☐ No | Genital Herpes | ☐ Yes ☐ No | Lung Disease | ☐ Yes ☐ No | Tonsilitis | ☐ Yes ☐ No |
| Bruise Easily | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Hay Fever | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Tumors or Growths | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Heart Attack/Failure | ☐ Yes ☐ No | Pain in Jaw Joints | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| Chest Pains | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Parathyroid Disease | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Cold Sores/Fever Blisters | ☐ Yes ☐ No | Heart Pacemaker | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Yellow Jaundice | ☐ Yes ☐ No |
| Congential Heart Disorder | ☐ Yes ☐ No | Heart Trouble/Disease | ☐ Yes ☐ No | Radiation Treatments | ☐ Yes ☐ No | | |
| Convulsions | ☐ Yes ☐ No | Hemophilia | ☐ Yes ☐ No | Recent Weight Loss | ☐ Yes ☐ No | | |
| Cortisone Medicine | ☐ Yes ☐ No | Hepatitis A | ☐ Yes ☐ No | Renal Dialysis | ☐ Yes ☐ No | | |

Have you had any serious illness not listed? ☐ Yes ☐ No If yes _____

## AUTHORIZATION RELEASE

To the best of my knowledge, the above information is complete and correct, I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insured coverage with _____ and assigned directly to
Name of insurance Company(ies)

Dr all insurance benefits, if any, otherwiser payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signed: _____ Date _____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient