Lowcountry Family & Cosmetic Dentistry

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

Name	· · · · · · · · · · · · · · · · · · ·	Employer			
AddressCity & Zip		Address	Employer Address City & Zip		
		City & Zip			
Home Telephone		vvork relephone	vvork relephone		
Home Telephone Birth Date		Name of Insured	Name of Insured		
SS#		Relation to Patient			
SS#Marital Status		Birth Date	Birth Date SS#		
Spouse / Parent		Insurance Co.	Insurance Co Group #		
Physician		Insurance Co. Addr	ess		
In Case of Emergency (Closet	Relative or Friend)	Referred By :	Referred By : How long since last dental check-up?		
Phone Number		How long since last	dental check-up?		
	Confidential Mo	edical History			
1. The reason for your dental vi	isit		•	(Circle)	
2. Are you having pain or disco		YES NO			
3. Do you feel very nervous abo	out having dental treatment?			YES NO	
	experience in the dentist's office	?		YES NO	
	t in the hospital during the past			YES NO	
6. Have you been under the care of a medical doctor during the past two years?					
7. Have you taken any medicine or drugs during the past two years?					
	g, rash, swelling of hands, feel		nicillin aspirin codeine	YES NO	
any drugs or medication?					
	bleeding requiring special trea	atment ?		YES NO YES NO	
	which you have had or have at			165 110	
Allergies or Hives		Heart Murmur	Rheumatic Fever		
Anemia		Heart Pacemaker	Rheumatism		
Angina Pectoris	Chemotheraphy, Leukemia		Scarlet Fever		
Artificial Heart Value	Drug Addiction	Hemophilia	Sickle Cell Disease		
Artificial Joint	Diabetes		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 (Syph	ilis Gonorrhea \	
Cold Sores	Heart Disease or Attack		X-ray Treatment	ilis, Collonnea)	
Congenital Heart Lesions		Psychiatric Treatment	Yellow Jaundice		
11. Do you grind or clench your		r by and and treatment	renow sauntine	YES NO	
12. When you walk up stairs or	r take a walk, do you ever have :	to stop because of pain in yo	ur chest,		
shortness of breath, or bed				YES NO YES NO	
13. Do your ankles swell during the day?					
14. Have you lost or gained more than 10 pounds in the last year?					
15. Do you ever wake up from sleep short of breath?					
16. Are you on a special diet?					
17. Has your medical doctor ever said you have cancer or a tumor?					
18. Do you have any disease, condition, or problem not listed?					
19. WOMEN: Are you pregnant now?					
Are you practicing birth control ?					
Do you anticipate becoming pregnant?					
					

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.

Clouder		
SIGNATURE	<u> </u>	DATE