

O2 Dental Group Of Southern Pines

340 Capital Drive

Carthage, NC 28327

Ph # : 910-839-0055



Patient Personal Information					
Title	Nickname	Birth Date	Age		
Last, First		Marital Status	Sex		
Address		Home #	Work #		
		Cell #	Drive Lic		
City, State, Zip		Emergency Contact	Emergency Phone #		
Email		Student	SSN		
Health Care Guardian Name		School Name			
Health Care Guardian Phone #		Referral Type			

Person responsible/guarantor for paying bills					
Title	Nickname	Birth Date	Age		
Last, First		Marital Status	Sex		
Address		Home #	Work #		
		Cell #	Drive Lic		
City, State, Zip		SSN			
Email					

Do you have Primary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have Secondary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Group No/Name			Group No/Name		
Insurance Name			Insurance Name		
Phone #			Phone #		
Employer Name			Employer Name		
Subscriber Last, First			Subscriber Last, First		
Subscriber Address			Subscriber Address		
City, State, Zip			City, State, Zip		
Relationship to Patient	Birth Date		Relationship to Patient	Birth Date	
Subscriber ID			Subscriber ID		

Patient Medical Information					
Allergic To	<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Persistent Diarrhea		
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate		
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment		
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever		
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease		
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis		
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures		
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease		
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath		
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash		
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble		
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers		
<input type="checkbox"/> Y <input type="checkbox"/> N Prior Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke		
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems		
<input type="checkbox"/> Y <input type="checkbox"/> N Other Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis		
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Color Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss		
		<input type="checkbox"/> Y <input type="checkbox"/> N Kidney			

- Y N No Change Since Last Recorded
- Y N No Known Concerns or Issues
- Y N Abnormal Bleeding
- Y N AIDS/HIV Infection
- Y N Alcohol/Drug Abuse
- Y N Angina
- Y N Anemia
- Y N Ankles Swell

- Y N Congenital Heart Defect
- Y N Contact Lenses
- Y N Congestive Heart Failure
- Y N Damaged Heart Valve
- Y N Diabetes
- Y N Emphysema
- Y N Environmental Allergies
- Y N Epilepsy

- Y N Leukemia
- Y N Liver Disease
- Y N Low Blood Pressure
- Y N Lupus
- Y N Mental Health Problems
- Y N Mitral Valve Prolapse
- Y N Pacemaker

- Y N Urinate Frequently
- Other**
- Y N See Scanned Documents: Pt Note

Additional Comments

Dental Questionnaire

Dental Questionnaire

Name of Previous Dentist _____

Phone Number of Previous Dentist _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Does food catch between your teeth ? _____

Do you want to learn to control your dental disease and retain your teeth ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? _____

If Yes, what ? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Have you ever taken the diet control drug Fen-Phen ? _____

Do you use alcoholic beverages ? _____

Do you smoke ? _____

Women Only

Are you pregnant? _____

If Yes, what is your due date ? _____

Are you currently nursing ? _____

Do you have menstrual period problems ? _____

Are you on hormone replacement therapy ? _____

Are you on birth control pills / fertility drugs ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date

Dentist Signature

Date