Berkeley Family Dentistry

Welcome to our practice. Thank you for selecting our dental healthcare team.
Please fill out this form completely and to the best of your ability.
If you have any questions or concerns, please ask for assistance. Please make our office aware at any time if your information changes.

Patient Name _____ Birthdate _____/_____/_____

Street Address _____ City _____ State____ Zip_____

Mailing Address_____ City_____ State____ Zip_____

Home Phone _____Work Phone _____ Cell Phone _____

Please circle the best number to reach you. Email _____

Employed by _____ Social Security Number _____

Sex _____ Marital Status _____ Referred by _____

Person Responsible for Account:

Name _____ Birthdate _____/_____/_____

Relationship to Patient _____Social Security Number_____

Address _____

Employer _____ Occupation _____

Dental Insurance _____ Policy Number _____

Secondary Insurance _____ Policy Number _____

Insured _____ Birthdate _____

Relationship to Patient _____ Social Security Number_____

DENTAL HISTORY

What is the reason for your visit today? _____

Do you have a previous dentist? _____

When was your last dental visit with x-rays? _____

How often do you brush? _____ Floss? _____

Do you have any loose, painful teeth, or sensitive teeth? YES NO In what area of your mouth? _____

MEDICAL HISTORY

What is the name of your physician? _____ Date of last physical exam: _____

Have there been any changes in your overall health in the last year?	YES	NO
Have you had any operations or been hospitalized in the past 5 years?	YES	NO
If yes, when? _____		
Do you have any prosthetic joints/implants?	**YES**	**NO**
If yes, please list type of replacement and date of surgery: _____		
Has a physician or dentist ever recommended you take antibiotics before dental treatment?	**YES**	**NO**
ARE YOU TAKING BLOOD THINNERS OR ASPIRIN?	**YES**	**NO**
If yes, please circle blood thinner or aspirin.		
Have you ever had abnormal bleeding or bruise easily?	YES	NO
Have you ever had a blood transfusion?	YES	NO

HAVE YOU EVER HAD (Circle YES or NO):

Rheumatic fever or rheumatic heart disease	**YES**	**NO**
Scarlet fever	**YES**	**NO**
Heart defect, heart murmur, mitral valve prolapse	YES	NO
Heart trouble, heart attack, or angina (chest pain)	YES	NO
High blood pressure	YES	NO
Shortness of breath	YES	NO
Asthma, respiratory or lung disease	YES	NO
Diabetes	**YES**	**NO**
Any blood disease (sickle cell, leukemia)	YES	NO
Liver disease or hepatitis	**YES**	**NO**
Kidney trouble and/or on dialysis	YES	NO
HIV or AIDS	YES	NO
Tuberculosis	YES	NO
Epilepsy	YES	NO
Cancer	YES	NO

Osteoporosis or any bone disease	YES	NO
Have you ever taken **IV bisphosphonates** (Aredia, Aclasta, etc)?	**YES**	**NO**
Are you taking or have you ever taken **oral bisphosphonates**?	**YES**	**NO**
(Fosamax, Boniva, Prolia, Reclast, etc.)		
Do you have any other medical conditions not listed above?	**YES**	**NO**
Please explain. _____		
Do you smoke or use tobacco products?	YES	NO
If yes, how much do you smoke? _____		
Do you use chewing tobacco?	YES	NO

Are you allergic to or have you had a reaction to:

Penicillin	**YES**	**NO**
Latex	**YES**	**NO**
Local Anesthetic	YES	NO
Any other antibiotic	YES	NO
Aspirin	YES	NO
Codeine	YES	NO
Sulfa	YES	NO
Any metals like mercury, nickel, etc.	YES	NO
Sulfites	YES	NO
Other: _____		

Women:

Are you pregnant?	YES	NO
Taking birth control?	YES	NO

Medications:

Please list all prescribed and over-the-counter medications you are taking, including dosages and frequency.

_____

_____

_____

_____

Are there any medications your doctor has prescribed that you are NOT taking? Please explain.

_____

Are you taking any drugs not prescribed by your doctor? _____

BERKELEY FAMILY DENTISTRY
EST. 1981

Drs. Horton and Jackson
421 Barony Street, Suite 7
Moncks Corner, SC 29461
843-761-7110

OFFICE POLICY

In order to better serve all of our patients:

- All patients must keep their appointments and BE ON TIME. If you are more than *10 minutes late* for your appointment, you may have to reschedule that appointment and return on a different day.
- If 3 appointments are broken, we will no longer be able to provide dental services.
- No shows or cancellations less than 24 hours in advance will be subject to a cancellation fee.
- Due to limited waiting room space, only one adult is allowed to accompany children being treated in this office. Please limit the number of people who come with you to one person.
- Only one person may accompany you or your child into an operatory.
- NO food or drinks are allowed in the waiting room.

FINANCIAL POLICY

Payment is expected on the day of treatment. If you have dental insurance, we will file it as a courtesy to you. However, **we require payment of the balance not covered by insurance on the date that treatment is rendered.**

If our office has not received payment from the insurance carrier after 60 days, the patient (or parent) will then be responsible for the entire balance. All balances 60 days past due are subject to a 1.5% monthly interest charge.

This is to certify that I have read and understand the **Office and Financial Policies**, and that I accept full responsibilities for the fees associated with dental treatment.

_____ _____

Signature of patient (parent or guardian) Date

I hereby acknowledge that a copy of this office's **Notice of Privacy Policy** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

_____ _____

Signature of patient (parent or guardian) Date