Dr. James ANDREWS
Comprehensive Dentistry

James C. Andrews, DMD PA

PATIENT

PATIENT LAST NAME	FIRST	MIDDLE	PREFERRED NAME TO BE CALLED	TODAY'S DATE	☐ MALE ☐ FEMALE
BIRTH DATE M D YR	SOCIAL SECURITY NUMBER		CELL PHONE		MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP
MAILING ADDRESS			HOME PHONE	CITY	STATE / ZIP CODE
EMAIL ADDRESS					DRIVER'S LICENSE NUMBER
EMERGENCY CONTACT			RELATIONSHIP	PHONE ( )	
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS			BUS. PHONE	OCCUPATION
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?					

IF PATIENT IS UNDER AGE 21 - FINANCIAL RESPONSIBILITY

LAST NAME	FIRST	MIDDLE	RELATIONSHIP	
ADDRESS			PHONE	
CITY			STATE	ZIP CODE

PRIMARY DENTAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		

SECONDARY DENTAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		

MEDICAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	MEMBER ID

DENTAL HISTORY

Darken the circle beside items that describe your past dental problems and dental care:

○ Regular dental care
○ Occasional dental care
○ Wisdom tooth extractions
○ Orthodontics
○ Gum disease (pyorrhea, gingivitis or periodontal disease)
○ Treatment for jaw trauma/fracture (Type?)_____
○ Had an adverse reaction to dental treatment (Please describe) _____
○ Dental fears or anxiety _____

Rate your ORAL HEALTH in general: ..... Excellent Very Good Good Fair Poor

How good do you feel you are doing in taking care of your oral health? Excellent Very Good Good Fair Poor

Date of last regular dental visit: ____ ____ (Month Year) Name of dentist: _____

Reason for today's visit: _____

What would your like to change about your smile? _____

_____

PRESCRIPTION / NONPRESCRIPTION MEDICATIONS

List all medications and herbal supplements/remedies that you are currently taking.

○ MARK HERE IF NONE

VERIFIED BY EXAMINER

Name	For what Condition?	Dose/Frequency of use
A)		
B)		
C)		
D)		
E)		
F)		

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care (6-month cleanings/implants/restorative/cosmetic)?	☐	☐
How often do you brush? _____		
How often do you floss? _____		
Do you currently wear a night guard?	☐	☐

	Yes	No	Don't Know
Does your jaw make noise so that it bothers you or others?	☐	☐	
Do you clench or grind your jaws frequently?	☐	☐	
Do your jaws ever feel tired?	☐	☐	
Does your jaw get stuck so that you can't open freely?	☐	☐	
Does it hurt when you chew or open wide to take a bite?	☐	☐	
Do you have ear aches or pain in front of the ears?	☐	☐	
Are you dissatisfied with the appearance of your teeth?	☐	☐	
Would you like whiter teeth?	☐	☐	
What would you change about your teeth? _____			
Would you like to replace any missing teeth?	☐	☐	
Do you snore?	☐	☐	☐
Have you ever fallen asleep while driving?	☐	☐	
Has anyone noticed that you quit breathing during your sleep?	☐	☐	
How often (darken the circle by the answer that applies)?			
○ Nearly every day ○ 3-4 times a week			
○ 1-2 times a week ○ 1-2 times a month			
○ Never or nearly ever			
Do you currently wear a CPAP?	☐	☐	
Have you been diagnosed with sleep apnea?	☐	☐	
Have you had a sleep study or told to get one?	☐	☐	

MEDICAL HEALTH HISTORY:

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

	Yes Currently	Yes In the Past	No
Heart Problems	☐	☐	☐
Chest pains	☐	☐	☐
Shortness of breath	☐	☐	☐
Blood pressure problem	☐	☐	☐
Heart murmur	☐	☐	☐
Heart valve problem	☐	☐	☐
Taking heart medication	☐	☐	☐
Rheumatic fever	☐	☐	☐
Pacemaker	☐	☐	☐
Artificial heart valve	☐	☐	☐
Blood Problems	☐	☐	☐
Easy bruising	☐	☐	☐
Frequent nosebleeds	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Blood disease (anemia)	☐	☐	☐
Ever require a blood transfusion?	☐	☐	☐
Allergy Problems	☐	☐	☐
Hay fever	☐	☐	☐
Sinus problems	☐	☐	☐
Skin rashes	☐	☐	☐
Taking allergy medication	☐	☐	☐
Asthma	☐	☐	☐
Intestinal Problems	☐	☐	☐
Ulcers	☐	☐	☐
Acid Reflux	☐	☐	☐
Bone or Joint Problems	☐	☐	☐
Arthritis	☐	☐	☐
Back or neck pain	☐	☐	☐
Joint replacement (i.e. total hip, pins, or implants)	☐	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐	☐
Stroke(s)	☐	☐	☐
Frequent or severe headaches	☐	☐	☐
Thyroid problems	☐	☐	☐
Persistent cough or swollen glands	☐	☐	☐
Premedications required by physician	☐	☐	☐
Cancer/Tumor	☐	☐	☐

Surgeries _____

_____

Are you allergic, or have you reacted adversely, to any of the following?	**Yes**	**No**
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other _____		

Notes: _____

_____

_____ Date: _____

	Yes	No
Diabetes	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you smoke / vape / chew tobacco?	☐	☐
If so, how much? _____		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐

If so, please describe: _____

During the past 12 months, have you taken any of the following?	**Yes**	**No**
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Fish Oil	☐	☐
Bone Density Medications	☐	☐
Chemotherapy/Radiation	☐	☐
Other		

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐

If so, do you have any symptoms?: _____

_____

Notes: _____

_____

_____

Patient/Parent Signature: _____

Dentist Initial: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If your insurance company has not paid within 60 days, full payment is required from the guarantor immediately. Our office will attempt, as a courtesy, to estimate your portion due; however, this is only an estimate. You are responsible for any charges your insurance company does not pay. Account balances over 90 days will be referred to collections. **Because of instruments, chairs, and personnel are reserved exclusively for your appointment, there is a $50.00 broken appointment fee**, if you fail to notify the office in adequate time (48 hours) for the appointment to be filled. A $5.00 dollar billing fee will be charged to your account if we are required to send more than one statement to collect a fee. There is a $50.00 processing charge for non-sufficient funds or returned checks. Records can be viewed at any time. There is a nominal charge for release or copies of records.

X_____ INITIAL

I understand a fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, I agree to pay within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost~ and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Photography Release: I, X_____, hereby authorize Dr. James Andrews or his assistants to take photographs, slides, and or video of my face, jaw, mouth and teeth. I understand that the photographs, slide and or videos will be used as a record of my care, and may be used for education purposes in study club meeting, lectures, seminars, demonstrations, and professional publications. I further understand that if the photographs, slides , and or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs. X_____ INITIAL

I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES AND AGREE TO THE POLICY. X_____ INITIAL
To the best of my knowledge all of the preceding answers and information are true and correct. If I ever have any change in my health , insurance or financial information, I will inform the office without fail.

X_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent , guardian or guarantor of payment/responsible party

How would you like us to communicate with you???

Our dental office sends appointment reminders, information about treatment, payment and insurance and other communications. Please tell us how you would like us to communicate with you. By signing this form, I consent to the following:
The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice:
Circle all that apply

- U.S. Mail
- Email
- Text
- Phone

Your name (Print):_____ Today's Date:_____

Signature: _____
Please call the dental office at 843-871-6351 right away if you get a new phone number or address!

Who may we communicate with?

We may release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s)

FROM (MM/DD/YY) _____ TO (MM/DD/YY) _____

Name (Family, Physician, etc)	Phone	Relationship