TERRACE HILL DENTAL CENTER, PLLC
6654 US Highway 98
Hattiesburg, MS 39402-7936

(601)264-5756
info@terracehilldental.com
terracehilldental.com

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

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Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

| | | |
|---|---|---|
| ☐ *Pre-Med - Amox | ☐ *Pre-Med - Clind | ☐ *Pre-Med - Other |
| ☐ ADD/ADHD | ☐ Allergies | ☐ Alzheimer's/Dementia |
| ☐ Anemia | ☐ Anxiety | ☐ Arthritis |
| ☐ Artificial Joints | ☐ Asthma | ☐ Blood Disease |
| ☐ Blood Thinner | ☐ Cancer | ☐ Chemotherapy TX |
| ☐ Clindamycin Allergy | ☐ Codeine Allergy | ☐ COPD |
| ☐ Depression | ☐ Diabetes | ☐ Dizziness |
| ☐ Drug Dependancy | ☐ Epilepsy | ☐ Erythro Allergy |
| ☐ Excessive Bleeding | ☐ Fainting | ☐ Fever Blisters |
| ☐ Fibromyalgia | ☐ Glaucoma | ☐ Head Injuries |
| ☐ Heart Disease/Surger | ☐ Heart Murmur/MVP | ☐ Hepatitis |
| ☐ High Blood Pressure | ☐ High Cholesterol | ☐ HIV/AIDS |
| ☐ Hormone Therapy | ☐ Jaundice | ☐ Kidney Disease |
| ☐ Latex Allergy | ☐ Liver Disease | ☐ Lupus |
| ☐ Mental Disorders | ☐ Migraines | ☐ Nervous Disorders |
| ☐ Osteoporosis | ☐ Other | ☐ Pacemaker |
| ☐ Penicillin Allergy | ☐ Pregnancy | ☐ Radiation Treatment |

- [ ] Reflux
- [ ] Respiratory Diseases
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stents
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfur Allergy
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

Please list ALL allergies to drugs, food, dye, etc

Medical Notes:

Are you now under the care of a physician for anything other than routine care?

( ) Yes ( ) No

If yes, please explain:

Physicians name, address, phone number:

Blood Pressure

Temperature

Have you been outside of the United States in the 21 days? If so, where?

Please list all medications including dosage that you are currently taking (especially blood thinners):

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What would you like to change most about your smile?

## I hereby, give permission to Terrace HIll Dental Center, PLLC, to provide treatment/services for me or the person I am signing for.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date:

Response Date: