CAROLINA PERIODONTICS

1064 Gardner Road, Suite 110, Charleston, SC 29407
(843)556-8778

Patient Information

Patient Name: _____ Date: _____
Last First MI

- ☐ **Male** ☐ **Female**
- ☐ **Married** ☐ **Single**
- ☐ **Child**

Birth Date: _____ Social Security Number: _____

Phone (Home) _____ (Cell) _____(Work) _____ Referred By_____

Email Address: _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ **HIV / AIDS**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Cancer/Tumors**
- ☐ **Chemotherapy**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Hay Fever/Sinus**
- ☐ **Head Injuries**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis** (Circle one) **A B C**
- ☐ **High Blood Pressure**
- ☐ **Kidney Disease**
- ☐ **Latex allergy**
- ☐ **Liver Disease**
- ☐ **Mental Disorders**
- ☐ **Nervous Disorders**
- ☐ **Osteoporosis**
- ☐ **Injections for Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Pregnancy**
- ☐ **Due Date_____**
- ☐ **Radiation Treatment**
- ☐ **Respiratory Problems / COPD**
- ☐ **Rheumatic Fever**
- ☐ **Smoker**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Ulcers**
- ☐ **Venereal Disease**
- ☐ **Other**
- ☐ **_____**

Please list any prescribed and over the counter medications that you take:

☐ **Please check this box if you do not take any medications.**

☐ **Please check this box if you take any Bisphosphonate medications or injections. List name _____.**

Are you allergic to any medications? If yes, please list.

☐ **Please check this box if you have no allergies.**

Have you ever had any complications following dental treatment?

☐ **Yes**
☐ **No**

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years?

☐ **Yes**
☐ **No**

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification?

☐ **Yes**
☐ **No**

If yes, please explain:

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at my next appointment.

_____

Signature of Patient, Parent or Guardian Date

Carolina Periodontics

Mark F. Yampolsky, D.D.S., M.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign This Acknowledgement)

I_____HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRATICES.

_____ _____ _____

Print Name Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from the acknowledgement.
- ☐ Other: _____.

☐ In addition to releasing my information to other healthcare providers and/or insurance companies, I authorize you to share my medical information to the following individuals: (example: parents)

_____ _____

Name Relationship

_____ _____

Name Relationship

- List in case of emergency person:

Name _____ Relationship _____ Cell: _____ Work: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

☐ Name of Patient Spouse: _____ ☐ Name person responsible for payment:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____. SS#: _____.Home: _____.Work: _____. Cell: _____.

EMPLOYMENT INFORMATION

The following information is for:

☐ Patient ☐ Parent or Guardian

☐ Patient Spouse ☐ The person responsible for payment

Employer's Name: _____

Employer's Phone Number: _____