

Welcome!

Dr. Cheryl B. Billingsley, D.D.S, P.C.

Name _____ M ___ F ___ Marital Status _____
Last First M. Int. Suffix
(If Child): Parent/Guardian Name _____
How do you wish to be addressed _____ Birth Date _____
SS# _____ Driver's License Number and State _____
Address _____
Employer _____ Business Address _____
Occupation _____
Phone: Home (____) _____ - _____
Cell (____) _____ - _____
Work (____) _____ - _____
Emerg (____) _____ - _____
Email _____

How did you hear about our office? _____
Other Family Members in this Practice? _____
In Event of Emergency, whom may we notify? _____
What is their contact information? _____

(Please also check the box for your preferred method of contact)

I agree that payment for all services rendered is due at the time of service unless otherwise agreed upon. In the event the amount due is not timely paid, I agree to pay a monthly service charge of 1.5% on any balance due after 60 days and in addition will be responsible for all collection costs including attorney's fees and court costs should collection be necessary. Release: I authorize Dr. Cheryl B. Billingsley, D.D.S, P.C to perform diagnostic procedures and treatment as may be necessary for proper dental treatment. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another health care professional or to the emergency contact as given in the response for "in the event of emergency" space.

I attest to the accuracy of the information on this page.

Signature _____ Date _____
(patient signature (or parent or guardian))

Dental History

Do you have a specific dental concern? _____ If yes, please explain _____
What are your long term goals for your oral health? _____
What are your expectations of our office? _____
When was your last regular visit? _____ How often are your routine dental exams? _____
Do you think you have active gum disease (gingivitis, periodontitis) or decay? _____
Do your gums ever bleed or are they sore or red? _____
Do you have any loose teeth? _____ Do you want to keep your remaining teeth? _____
Do you floss regularly? _____ How often and type of floss? _____
Do you brush regularly? _____ Your routine and how long do you brush: _____
What type of toothbrush (i.e. hand/electric and brand as well as type i.e. soft/medium/hard) and toothpaste do you use? _____
How do you feel about your smile? _____
Is there anything you would like to change about it? _____
Have you ever considered brightening your smile? _____
Have you ever whitened your teeth? _____ If so, how and with what products? _____
Have you ever had orthodontics? _____ When _____
Have you ever had any jaw pain or discomfort in your jaw joint? _____
Do you, or has anyone ever told you that you grind or grind your teeth? _____
If so, do you wear an appliance to (i.e. nightguard) to protect your teeth? _____
Do you or has anyone ever told you that you snore or have sleep apnea? _____
Have your past dental experiences always been positive? _____
If not, would you like to explain? _____ (Optional)
Name of your previous dentist? _____ Last date of visit? _____ (Optional)
Reason for changing to our office? _____ (Optional)
Date of last xrays? _____ Type of Xrays _____
Tobacco and Alcohol Use History
Tobacco Use: Do you smoke? _____ Do you use smokeless tobacco, snuff, or chew? _____
How much do you smoke or use? _____ How long have you smoked or used it? _____
Have you ever tried to quit? _____ Would you be interested in quitting now or in the future? _____
Alcohol Use: Do you drink? _____ If so, how many drinks per week? _____ For how many years? _____
Have you ever noticed any sores or growths in your mouth? _____

Patient Name: _____

Dental History

Do you have a physician whom you see regularly? _____ If so please provide the following information:

Physician's Name _____ Phone _____ Fax _____

Address _____ City _____

(If not, would you like a referral or recommendation? _____)

Date of your last bloodwork tests? _____ Did it contain a CRP test? _____ If so, please list _____

Do you need ANTIBIOTIC PREMEDICATION prior to your dental appointments? _____

Have you ever taken fen-phen? _____

Have you ever been hospitalized or had a major operation? _____ Please discuss

Have you ever had a serious injury to your head or neck? _____ Please discuss

Are you taking any medications, pills, drugs, vitamins, or nutritional supplements? Please list:

Medication	Dosage	Reason	Medication	Dosage	Reason
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you have any allergies to any medications or substances? (Please circle and/or list)

Penicillin Latex Metal Aspirin Codeine Acrylic

Other _____

For women: are you - Pregnant/trying to get pregnant Nursing Taking oral contraceptives
(Please also check the box if applicable)

Do you have or have you ever had any of the following? (Please circle all that apply to yourself)

Heart Disease/Surgery*	Bruise Easily/Blood disease	Ulcers	Cortisone Medication
Heart Murmur*	Anemia	Recent Weight Loss	Artificial Joints*
Irregular Heart Beat	Sickle Cell disease	Diabetes (If so, what does your blood sugar run? _____)	Venereal Disease
Angina/Chest Pain	Hemophilia (bleeding problem)	Excessive Thirst	AIDS or HIV Positive
Heart Attack/Failure	Leukemia	Hypoglycemia	Herpes
Congenital Heart Disorder	Recent Blood Transfusion	Liver Disease	Colds Sore/Fever Blisters
Mitral Valve Prolapse (with regurgitation)	Swelling of Limbs	Hepatitis A (Infectious)	Alcohol or Drug Addiction
Scarlet Fever	Lung Disease	Hepatitis B or C	Stroke
Rheumatic Fever*	Sinus Trouble	Night sweats	Convulsions/Epilepsy/Seizures
Artificial Heart Valve*	Asthma	Kidney Problems	Fainting or dizziness
Cardiac Pacemaker*	Emphysema	Renal Dialysis*	Glaucoma
Pulmonary shunt	Tuberculosis	Thyroid Disease	Tumors or Growths
High Blood Pressure	Cancer* List type _____	Arthritis/Gout	Psychiatric Care
Low Blood Pressure	X-ray Treatments (Radiation)	Rheumatism	Alzheimers Disease
Bacterial endocardidits*	Chemotherapy		Hives/Rash
	Stomach Intestinal Disease		Nervousness

Or

OR

I affirm that I do not and have never had any of the above conditions _____ Date _____

Have you had any other serious illness not checked above? Yes or No. If yes, please discuss:

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if my medications change, I shall inform the dentist and the staff at the next appointment without fail.

Signature _____ Date _____

patient signature (or parent or guardian)

MEDICAL HISTORY FORM Reviewed by **Dr. Cheryl B. Billingsley, D.D.S, P.C** _____ Date _____