GRAND STRAND DENTISTRY
BRIAN K. ARMSTRONG, D.M.D.
Family Dentistry

Patient's First Name: _____ Middle Initial: ___ Last Name: _____

Preferred Name: _____ Marital Status: _____ Date of Birth: _____

Address: _____ City: _____ St: _____ Zip: _____

SS#: _____ Home # _____ Cell # _____

Email Address: _____

Who referred you to our office? _____

Employer: _____ Business Phone: _____ Ext: _____

Spouse's Name _____ Employer: _____ Business Phone: _____

MINOR PATIENTS: Parent/Guardian Name: _____ SS# _____
Parent/Guardian Employer: _____ Business Phone: _____

In case of an Emergency: Contact Name: _____ Home # _____

Physician's Name: _____ Phone # _____

Pharmacy: _____ Phone# _____

DENTAL INSURANCE INFORMATION

Insurance Name: _____ Insured's Name: _____ Insured DOB: _____
ID/SS# of Insured: _____Group # _____ Phone # _____

Patient's Name: _____

HEALTH/DENTAL HISTORY

Chief Dental Complaint: _____ Date of last dental visit? _____

Please indicate Yes or No for the following:

Bad Breath:	Yes ___ No ___	How often do you floss? _____
Bleeding Gums or Mouth	Yes ___ No ___	How often do you brush? _____
Burning sensations on tongue	Yes ___ No ___	
Chew on one side of mouth	Yes ___ No ___	Are you pregnant? _____ Which Month? _____
Cigarette, Pipe, or Cigar Smoking	Yes ___ No ___	
Clicking or popping in jaw	Yes ___ No ___	Are you allergic to/ Dental Anesthetics? _____
Dry Mouth	Yes ___ No ___	or have had Penicillin/Antibiotics? _____
Fingernail Biting	Yes ___ No ___	a reaction to: Latex? _____
Grinding Teeth	Yes ___ No ___	Nickel? _____
Loose or broken fillings	Yes ___ No ___	Aspirin? _____
Mouth Breathing	Yes ___ No ___	Other Drugs? _____
Mouth pain when brushing	Yes ___ No ___	
Orthodontic Treatment	Yes ___ No ___	Have you ever had any difficulties associated with dental
Pain around ear	Yes ___ No ___	treatment? _____
Periodontal Treatment	Yes ___ No ___	
Sensitive Hot/Cold/Sweets	Yes ___ No ___	Has there been any changes in your general health in the
Growths in Mouth	Yes ___ No ___	past 5 years? _____

Please circle Y or N to the following questions regarding your medical conditions you have or have had:

Rheumatic Fever	Y or N	Heart Problems	Y or N	Hepatitis	Y or N	Gland Problems	Y or N
Heart Disease	Y or N	Abnormal Bleeding	Y or N	Aids/HIV Pos	Y or N	Prosthetic Joints	Y or N
Blood Disorders	Y or N	Seizures	Y or N	Heart Murmur	Y or N	Stroke/Circulation	Y or N
Allergies	Y or N	Glaucoma	Y or N	Angina	Y or N	Heart Valve Problems	Y or N
Tuberculosis	Y or N	Diabetes	Y or N	Jaw Pain	Y or N	Mitral Valve Prolapse	Y or N
Epilepsy	Y or N	High Blood Pressure	Y or N	Stomach Ulcer	Y or N	Joint Replacement	Y or N
Kidney Problems	Y or N	Blood Transfusion	Y or N	Cancer/Tumor	Y or N	Thyroid Problems	Y or N
Acid Reflux	Y or N	Respiratory Disease	Y or N	Radiation Tx	Y or N	Venereal Disease	Y or N
Sex Trans Disease	Y or N						

PREMED NEEDED? Y or N (ex: For Hip/Knee Replacements or Heart Issues)

Please list all medications:

To the best of my knowledge, the provided medical/dental/history is correct. I consent to such examinations, x-rays, and diagnostic procedures and test that may be prescribed. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic and indicated photos, and releasing of information to my insurance company. I will assume responsibility for fees associated with any of the above.

Patient's (Parent/Guardian) Signature: _____ Date: _____