Stedman Family Dental Center
6540 Clinton Road
Stedman, NC 28391

Patient Name: _____
Chart No: _____
Date Of Birth: _____

DATE: _____

Name of Your Physician: _____ Office Telephone: _____

Address of Your Physician: _____

Name of Your Pharmacy: _____

1. Have you ever been hospitalized, had any major operations or had any serious illnesses?.....Yes No
   If yes, explain: _____
   _____
   _____
2. Have been under a physician's care in the last 2 years? .....Yes No
   If yes, explain: _____
   _____
   _____
3. With regard to cigarette smoking, how would you classify yourself? Current smoker Ex-smoker Never smoker
4. Do you currently use smokeless tobacco (e.g., snuff, plug)? .....Yes No
   If yes, about how many times do you use smokeless tobacco per day? Less than 1 1-5 6-10 11-20 more than 20
5. Do you currently drink alcoholic beverages? .....Yes No
   If yes, about how many drinks do you have per week? Less than 1 1-5 6-10 11-20 more than 20
6. Do you have (or have you ever been told you had) any of the following conditions? (circle all that apply)
   a. Congenital heart problems
   b. Infective endocarditis or other heart infection
   c. Artificial heart valves
   d. Heart Transplant
   e. Artificial joints or prostheses

7. Have you ever had an allergic reaction, or any other unusual reaction, to any of the following medications or substances?
   If yes, what reaction(s) did you have to this substance? (circle all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **A** | **Penicillin** | **Yes No** | **Rash** | **Swelling** | **Upset Stomach** | **Vomiting** | **Other reaction (explain)** |
| **B** | Sulfa or other antibiotics | Yes No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain) |
| **C** | Aspirin | Yes No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain) |
| **D** | Codeine or morphine | Yes No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain) |
| **E** | Dental anesthetic (e.g. Novocain or lidocaine) | Yes No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain) |
| **F** | Latex | Yes No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain) |
| **G** | Airborne substances (e.g. pollen, perfume) | Yes No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain) |
| **H** | Other medications or substances (explain) | | | | | | |

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8. Do you have (or have you ever been told you had and of the following conditions?

| | | | | |
|---|---|---|---|---|
| A | High blood pressure (hypertension) | Yes | No | Don't know |
| B | High cholesterol | Yes | No | Don't know |
| C | Heart disease (e.g. angina, coronary artery disease, congestive heart failure) | Yes | No | Don't know |
| D | Diabetes (sugar disease, blood sugar problems) | Yes | No | Don't know |
| E | Cancer or tumors | Yes | No | Don't know |
| F | Inflammatory diseases (e.g. arthritis, rheumatism, lupus, fibromyalgia) | Yes | No | Don't know |
| G | Frequent headaches | Yes | No | Don't know |
| H | Asthma, emphysema, or other lung disease | Yes | No | Don't know |
| I | Thyroid problems | Yes | No | Don't know |
| J | Epilepsy or seizure disorders | Yes | No | Don't know |
| K | Fainting or dizzy spells | Yes | No | Don't know |
| L | Hepatitis or other liver disease | Yes | No | Don't know |
| M | Tuberculosis (TB) | Yes | No | Don't know |
| N | HIV+ or AIDS | Yes | No | Don't know |
| O | Blood disorders (e.g. anemia, hemophilia) | Yes | No | Don't know |
| P | Kidney disease | Yes | No | Don't know |
| Q | Stomach or intestinal problems | Yes | No | Don't know |
| R | Phobias, sever anxieties, depression or other psychological problems | Yes | No | Don't know |
| S | Radiation, surgery, or chemotherapy to treat cancer | Yes | No | Don't know |
| T | Bleed excessively after being cut or receiving dental care | Yes | No | Don't know |
| U | Heart attack, stroke, or coronary bypass operation | Yes | No | Don't know |
| V | Shortness of breath after climbing 1 flight of stairs | Yes | No | Don't know |
| W | Pacemaker | Yes | No | Don't know |
| X | Pregnant or think you may be pregnant | Yes | No | Don't know |
| Y | Breastfeeding | Yes | No | Don't know |

Z. Are there any other problems or issues about your health that you know of? .....Yes No

If yes, explain: _____

_____

_____

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9. Have you ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease (e.g. Fosamax, Zometa, Actonel, Aredia)? .....Yes No

10. Are you currently taking any medications or substances, including over-the-counter, prescription, vitamin, or herbal products, for any reason? Please list below.....Yes No Don't Know

Medications or substances (with dosage)

_____
_____
_____
_____
_____
_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature: _____ Date: _____
If other than patient, indicate relationship to patient: _____
Provider Signature: _____

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1. What is you major dental concern? (circle all that apply)
   I need a dental checkup  My teeth hurt  My gums hurt
   I have some teeth that are chipped or broken  I don't like that appearance of my teeth or gums

2. How long ago was your last dental checkup and/or cleaning?
   Less than 1 year ago  1-2 years ago  More than 2 years ago  I've never had a dental checkup and/or cleaning

3. How often do you brush your teeth?
   More than once a day  Once a day  Once or twice a week  Hardly ever  Never

4. How often do you use dental floss?
   More than once a day  Once a day  Once or twice a week  Hardly ever  Never

5. Which of the following oral health care products do you use regularly? (circle all that apply)
   Fluoridated toothpaste  Fluoridated mouthrinses  Fluoridated water at home  Other Fluoridated products
   Other non-fluoridated products

Do the following things happen often enough to bother you?

| | | | |
|---|---|---|---|
| 6. | Food or dental floss gets caught between my teeth | Yes | No |
| 7. | Gums bleed or hurt when I brush my teeth | Yes | No |
| 8. | My teeth are sensitive to heat | Yes | No |
| 9. | My teeth are sensitive to cold | Yes | No |
| 10. | My teeth are sensitive to biting | Yes | No |
| 11. | My teeth are sensitive without any stimulus at all | Yes | No |
| 12. | I clench or grind my teeth | Yes | No |
| 13. | I have pain or clicking in my jaw joints | Yes | No |
| 14. | I get sores in my mouth | Yes | No |
| 15. | I have bad breath | Yes | No |

16. Which of the following dental treatments have you had? (circle all the apply)
    Root Canal Therapy  Crowns ("Caps")  Bridges  Removable Dentures  Tooth Removal  Gum Surgery
    Dental Implants

17. Which statement best describes your approach to dental care? (circle one)
    I go to the dentist regularly even if I don't have problems
    I don't go to the dentist unless I have a problem

18. Have you ever had problems or complications with previous dental treatment? .....Yes No

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19. Is there anything about dental care that worries you or that you strongly dislike? .....Yes No

20. Do you have any questions about your teeth, gums, or oral health? .....Yes No

# STEDMAN-WADE HEALTH SERVICES, INC.

## ANNUAL PATIENT INFORMATION UPDATE

January – December _____

PATIENT NAME: _____ DOB: _____

PHONE #: _____ CELL/WORK #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

RELATIONSHIP TO EMERGENCY CONTACT: _____

NEXT OF KIN: _____ PHONE #: _____

EDUCATION LEVEL: _____ HOMELESS STATUS: YES or NO

HEALTH INSURANCE: _____ VETERAN: YES or NO (Circle one)

## YEARLY HOUSEHOLD ESTIMATE

STEDMAN-WADE HEALTH SERVICES, INC. IS REQUIRED TO REPORT INCOME DATA ON OUR PATIENTS IN ORDER TO RECEIVE FEDERAL FUNDING TO SERVE THE UNINSURED. THIS INFORMATION **IS** CONFIDENTIAL. REPORTING IS AGGRAGATE AND NOT PATIENT SPECIFIC.

**YEARLY HOUSEHOLD ESTIMATE**
**PLEASE CIRCLE INCOME AND FAMILY SIZE**

| Size of Family Unit | Income | Income | Income | Income | Income |
|---|---|---|---|---|---|
| 1 | 0–11,770 | 11,771–14,713 | 14,714-17,655 | 17,656-20,598 | 20,599-22,363 |
| 2 | 0-15,930 | 15,931-19,913 | 19,914-23,895 | 23,896-27,878 | 27,879-30,267 |
| 3 | 0-20,090 | 20,091-25,113 | 25,114-30,135 | 30,136-35,158 | 35,159-38,171 |
| 4 | 0-24,250 | 24,251-30,313 | 30,314-36,375 | 36,376-42,438 | 42,439-46,075 |
| 5 | 0-28,410 | 28,411-35,513 | 35,514-42,615 | 42,616-49,718 | 49,719-53,979 |
| 6 | 0-32,570 | 32,571-40,713 | 40,714-48,855 | 48,856-56,998 | 56,999-61,883 |
| 7 | 0-36,730 | 36,731-45,913 | 45,914-55,095 | 55,096-64,278 | 64,279-69,787 |
| 8 | 0-40,890 | 40,891-51,113 | 51,114-61,335 | 61,336-71,558 | 71,559-77,691 |

_____ _____

**PATIENT SIGNATURE** **DATE**

_____ _____

**PATIENT CARE REPRESENTATIVE** **DATE**