Frank V. Sullivan DDS., LVIF.
General Dentist

Clay Couvillon DDS.
General Dentist

Sullivan DENTAL CENTER

Candice R. Sullivan DDS.
Pediatric Dentist

Aaron Priddy DDS.
General Dentist

Date _____
Patient Name _____ Driver's License # _____
Mailing Address _____ City _____ Zip Code_____
Birthdate_____ Social Security # _____
Employer_____ Work Phone _____
Home Phone _____ Cell Phone _____ Email Address _____

INSURANCE INFORMATION

Person responsible for Account if different from patient or Insurance carrier: _____
Mailing Address _____ City _____ Zip Code _____
Relationship to Patient _____ Insurance Company (if applicable) _____
Birthdate _____ Social Security # _____
Employer _____ Insurance Mem ID# _____
Cell Phone _____Email Address _____

Patient's Spouse's Name _____ Social Security # _____
Spouse's Employer _____ Cell Phone_____

EMERGENCY INFORMATION

Nearest friend or relative not living with you _____
Phone Number _____

GETTING TO KNOW YOU

Why did you select our office? _____
Whom may we thank for referring you? _____ Phone _____
Is another member of your family a patient at our office? _____
When was your last dental visit? _____ Last Dentist? _____
Have you ever had any teeth removed? _____
How long have these teeth been missing? _____
Have these teeth been replaced? _____
How? Bridge ☐ Partial ☐ Denture ☐ Implants ☐

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by this office.

_____

Signature of responsible Party Relationship Date

Turn over to complete →

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years..... ☐ YES ☐ NO
   If yes, for what reason? _____
2. Please provide the name, address, and telephone number of your physician.
   _____
3. Are you having dental problems at this time? ..... ☐ YES ☐ NO
4. Do your gums bleed at any time? ..... ☐ YES ☐ NO
5. Do you feel very nervous about having dental treatment? ..... ☐ YES ☐ NO
6. Have you ever had a bad experience in the dental office? ..... ☐ YES ☐ NO
7. Have you been a patient in the hospital during the past two years? ..... ☐ YES ☐ NO
8. Have you ever taken any medicine or drugs during the past two years? ..... ☐ YES ☐ NO
9. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... ☐ YES ☐ NO
   If yes, please list. _____
10. Have you ever had excessive bleeding requiring special treatment? ..... ☐ YES ☐ NO
11. Check any of the following which you have had or have at present:

☐ Heart Failure	☐ Kidney Trouble	☐ Genital Herpes
☐ Heart Disease or Attack	☐ Ulcers	☐ Epilepsy or Seizures
☐ Angina Pectoris (chest pain)	☐ Shortness of Breath	☐ Fainting or Dizzy Spells
☐ Tuberculosis (TB)	☐ Emphysema	☐ X-Ray or Cobalt Treatment
☐ Asthma	☐ Hepatitis B (Serum)	☐ Chemotherapy (Cancer, Leukemia)
☐ Rheumatic Fever	☐ Liver Disease	☐ Arthritis
☐ Congenital Heart Lesions	☐ Yellow Jaundice	☐ Rheumatism
☐ Scarlet Fever	☐ Hay Fever	☐ Cortisone Medication
☐ Artificial Heart Valve	☐ Allergies or Hives	☐ Glaucoma
☐ Heart Surgery	☐ Diabetes	☐ Pain in Jaw Joints
☐ Artificial Joint	☐ Thyroid Disease	☐ HIV positive (AIDS)
☐ Anemia	☐ Hemophilia	
☐ Stroke	☐ Venereal Disease (Syphilis, Gonorrhea)	
☐ Hepatitis A (infectious)	☐ Cold Sores or Fever Blisters	☐ Psychiatric Treatment
☐ High Blood Pressure	☐ Bruise Easily	☐ Sickle Cell Disease
☐ Heart Murmur/ Mitral Valve	☐ Blood Transfusion	
	☐ Drug Addiction	
	☐ Nervousness	

12. List all medications you are taking at this time. _____
13. Are you a smoker? ..... ☐ YES ☐ NO
14. Do you use or have you ever used recreational drugs? ..... ☐ YES ☐ NO
15. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired? ..... ☐ YES ☐ NO
16. Do your ankles swell during the day? ..... ☐ YES ☐ NO
17. Have you lost or gained more than 10 pounds in the last year? ..... ☐ YES ☐ NO
18. Do you ever wake up from sleep short of breath? ..... ☐ YES ☐ NO
19. Do you use more than 2 pillows to sleep? ..... ☐ YES ☐ NO
20. Are you taking or have you ever taken Fosamax or Boniva? ..... ☐ YES ☐ NO
21. Has your medical doctor ever said you have cancer or a tumor? ..... ☐ YES ☐ NO
22. Women: Are you pregnant? ☐ YES ☐ NO If yes, what month are you due? _____
    Are you taking birth control pills? ..... ☐ YES ☐ NO

- Do you have any disease, condition or problem not listed? ..... ☐ YES ☐ NO
  If so, please list. _____
- Have you ever been diagnosed with sleep apnea? Do you snore? _____
- How do you feel about the appearance of your teeth? _____
- If you could change anything about your smile, what would you change? _____
  _____