ERIC R. NEASE, D.D.S., M.D.S.
PHILIP R. HIGGINBOTHAM, JR., D.D.S., M.S.
Practice Limited to Orthodontics
2455 E. Main Street · Spartanburg, SC 29307 · 864-579-7700
1785 E. Main Street · Duncan, SC 29334
424 Hyatt Street, Suite E · Gaffney, SC 29341

www.drnease.com

Patient Information

Date _____ Age _____ Dentist _____

Patient's Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

E-Mail Address _____ Mobile Phone _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ _____
First Middle Last Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
First Middle Last

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____ Employer's Phone No. _____

If you are covered, for dental, by a second Insurance Co. , please fill out below:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____ Employer's Phone _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Are you aware that some appointments will infringe upon work or school time? _____

Signature (Parent's signature if minor) _____

I understand that where appropriate, credit bureau reports may be obtained.

Review with patient by _____

Date _____

Medical History

Physician _____ Date of last visit _____

Address _____ Phone _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding / Hemophilia	Diabetes	Hepatitis / Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation / Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV +/ AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Dental History

Dentist _____ Date of last visit _____

Address _____ Phone _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

_____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth or teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

_____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? _____

Yes No Has anyone in the family received orthodontic treatment? _____

How did they feel about the result? _____

What is your attitude toward receiving orthodontic treatment? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

_____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Are you aware that some appointments will be during school/work hours? _____

Benefits or Orthodontics

AESTHETICS, HEALTH, AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand the above paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

_____ _____

Patient Parent Date