William D. Stewart, D.M.D., P.A.
1327 Drayton Road
Spartanburg SC, 29307

WILLIAM D. STEWART
FAMILY DENTISTRY

Today"s Date ____________

Welcome to our office and thank you for choosing our office for your dental needs. We ask that you complete the following information so that we can offer you the best treatment possible.

Patient Information

First Name ________ Initial ____ Last Name ________ Preferred Name ________ SSN ________

Home Address ________ Mailing Address ________ Home Phone ________ Date of Birth ________ Sex ________

City ____ State ____ Zip ____ City ____ State ____ Zip ____ Mobile Phone ________ Marital Status ________

Email ________ Referred By ________ Spouse's Name ________

Occupation ________ Employer ________ Work Phone ________

Work Address ________ Work Mailing Address ________

☐ Please check if you are completing this form for another person

City ____ State ____ Zip ____ City ____ State ____ Zip ____

Name ________

Emergency Contact ________ *Not in the same household* Emergency Phone ________

Relationship ________

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	◯ Yes	◯ No	Name of physician: ________
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	If yes, please explain: ________
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, please explain: ________
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No	If yes, please list: ________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes	◯ No	
Are you on a special diet?	◯ Yes	◯ No	
Do you use tobacco?	◯ Yes	◯ No	
Do you use controlled substances?	◯ Yes	◯ No	

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please list: ________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illnesses not listed above? ◯ Yes ◯ No

If yes, please explain: ________

Comments ________

Payment Policy

Our office endeavors to make our dental services affordable and to work with you to make financial arrangements. We accept cash, check, VISA and MasterCard credit cards. We are willing to help patients arrange financial payments if they are not able to pay for all dental services when rendered.

Dr. Stewart offers a payment plan tailored to each patient's situation. In house payment plans with no interest are available when arranged prior to treatment.

For patients who need longer financing options, we have CareCredit available, a third party payment service that gives you a way to consolidate and manage out-of-pocket payments for dental procedures. They offer payment plans with low monthly payments and special financing rates.

☐ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ________ DATE ________