P. Spencer Witkin, D.M.D.

415-A Robertson Boulevard
Walterboro, South Carolina 29488

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information:

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET APT #

_____
CITY STATE ZIP

Birth Date _____ ❑ Male ❑ Female
Employer _____

❑ Married ❑ Single ❑ Other
Phone: Home (_____) _____

Work (_____) _____

Cell (_____) _____ Email _____

Emergency Contact: Name _____ Phone (_____) _____

If Patient Is Under 18 Years Old:

Responsible Party _____ Phone: (_____) _____ Relationship to Patient _____

The information on this page is correct to the best of my knowledge: (SIGN AND DATE)

X_____ _____
PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

Health History

Primary Physician's Name:_____

Have you had a serious illness or operation? Y ❑ N ❑ If yes, please describe: (Anything that would hinder dental treatment)

_____

Are you currently under physician care? Y ❑ N ❑
If yes, please describe:

_____

Do you Smoke or use Tobacco? Y ❑ N ❑

Are you pregnant? Y ❑ N ❑ if yes, # of weeks _____ Are you nursing? Y ❑ N ❑

Please circle those conditions that have ever applied to you:

Conditions

Abnormal Bleeding
Allergies
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Asthma
High Cholesterol
Cancer
Chemotherapy
Heart Attack
Congenital Heart Defect
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
HIV+Aids
Joint Replacement, year_____
Heart Murmur
Heart Surgery
Hepatitis A, B, C
High Blood Pressure
Kidney Problems
Liver Disease
Pace Maker
Radiation Therapy
Seizures
Sexually Transmitted Disease
Shingles
Sickle Cell
Sinus Problems
Stroke
Thyroid problems
Tuberculosis
Ulcers

Allergies

***Aspirin**
***Codeine**
***Erythromycin**
***Latex**
***Metals**
***Penicillin**
***Sulfa**
***Morphine**
***Other: _____**
*** None**

Do you take a blood thinner? Y ❑ N ❑

Please list any medications you are currently taking:

_____

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

X_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**