Georgia Dental Medicine
1225 Johnson Ferry Road,
Suite 660
Marietta GA 30068
(770) 973-6494

New Patient Medical & Dental History (please complete accurately and legibly)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that assists in your overall health and well-being. If this form contains information from a recent visit, simply correct any errors, add any additional information needed and sign on the last page.

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Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Would you consider your overall health to be:

* ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If there have been any changes in your general health in the past year, please list those changes below:

What is the date (or approximate date) of your last complete physical?

Your Primary Care Physician's name and address, & phone number:

Please check any of the following to indicate a YES in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Are you taking any Osteoporosis Medication (esp bisphosphonates such as Fosamax, Actonel, Boniva, etc)?

☐ Do you have an active case of tuberculosis or have been exposed to anyone with tuberculosis?

☐ Persistent cough greater than a 3-week duration and/or a cough that produces blood?

☐ Do you use controlled substances or recreational drugs?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are checked, please explain as necessary:

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REQUIRED: Emergency Contact Names and Phone#s:

*

Have you ever been told to take an Antibiotic before visiting the Dentist?

* ☐ Yes ☐ No

What Medication are you taking now (please include all prescription and non-prerscription medications, including vitamins, natural or herbal preparations and diet supplements):

WOMEN ONLY: If pregnant, what is your due date?

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Please select to indicate each item below that you have and /or are experiencing or have ever been treated for:

- [ ] Acrylic Allergy
- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Clotting Pbm
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Bronchitis
- [ ] Cancer
- [ ] Codeine Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Valve Replaced
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Immune System Pbm
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease/Pbm
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] NO NITROUS
- [ ] Osteoporosis Meds
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Pre Medicate needed
- [ ] Pregnant (Currently)
- [ ] Radiation Treatment
- [ ] Reflux/Heartburn
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] SEE NOTES
- [ ] Shortness of Breath
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Vertigo/Ear Pbm

IMPORTANT Do you have any other health issues or allergies (include all allergies including but not limited to Penicillin, Codeine, Novocain/Food Allergies/Latex/Acrylic allergies) or need to clarify any of the selected items above? If so, please be detailed:

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Reason for Dental Visit and Dental Habits:

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

If you have been or are currently being treated by an Orthodontist, what is their name and when was your last visit?

May we contact your prior Dentist to obtain medical records (X-Rays, etc.)?

☐ Yes ☐ No

How often do you usually see a Dentist?

☐ Every 3 Months ☐ Every 4 Months ☐ Every 6 Months
☐ Every Year ☐ Occasionally ☐ When something hurts

Have you ever had a bad experience at the Dentist?

☐ Yes ☐ No

Are you nervous about coming to the Dentist?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

How frequently do you brush your teeth?

☐ 3 (+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth?

☐ 1 (+) a day ☐ 2 - 6 weekly ☐ 1 - 6 monthly ☐ Seldom ☐ Never

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Dental Concerns:

Please check any of the questions below to indicate "YES" in response to the question, if applicable:

- ☐ Pain: do any of your teeth cause you pain?
- ☐ Bleeding Gums: do your gums bleed when you brush or floss?
- ☐ Bad Taste: do you have a consistent bad taste in your mouth?
- ☐ Bad Breath: do you have bad breath quite often?
- ☐ Sensitivity to Hot/Cold: are you sensitive to hot/cold?
- ☐ Jaw Pain or Soreness?
- ☐ Jaw clicks/pops/locks?
- ☐ Loose Teeth: Are any of your teeth loose or loosening?
- ☐ Food gets stuck between Teeth: on a regular basis
- ☐ Clenching Teeth
- ☐ Grinding Teeth: either consciously or during sleep?
- ☐ Mouth Ulcers
- ☐ Cold Sores
- ☐ Dry Mouth (xerostomia)?
- ☐ Have had periodontal (gum) treatments?
- ☐ Have you ever had orthodontic (braces) treatment?
- ☐ Dentures/Implants: do you currently have any dental implants, dentures, or partials?
- ☐ Ever had a serious injury to your head, mouth or jaw?

If any of the previous questions are marked or you have any other dental concerns, please explain further:

If you could change anything about your mouth, teeth, or smile, what would it be?

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Authorization

I hereby certify that I have accurately completed, to the best of my knowledge, the information provided above.

I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the office of Georgia Dental Medicine to release any necessary information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners as part of dental treatment or payment for such treatment.

I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

To the best of my knowledge, all of the preceding information is true and correct.

If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature of patient (if 18 or older) and parent/guardian/financially responsible party:

Signature: _____ Date: _____

Relationship to Patient (if signature above is not the patient):

_____

Thank you for taking the time to complete or update your Medical Records.

Response Date: _____