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NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ AGE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ MOBILE PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ E-MAIL \_\_\_\_\_  
PREVIOUS ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK # \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_  
NAME OF PARENT (IF MINOR) \_\_\_\_\_ SS# \_\_\_\_\_  
SPOUSE'S NAME \_\_\_\_\_ SS# \_\_\_\_\_  
ADDRESS IF DIFFERENT FROM PATIENT'S \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK # \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_  
REFERRED BY \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_  
FORMER DENTIST \_\_\_\_\_  
NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURANCE CO. \_\_\_\_\_ PHONE # \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SS# \_\_\_\_\_ GROUP # \_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## Medical History

Patient Name \_\_\_\_\_ Medical Alerts \_\_\_\_\_

1. Have you been under the care of a medical doctor during the past two years? \_\_\_\_\_ Yes/No  
 If yes, for what? \_\_\_\_\_  
 Physician's name \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? Yes/No. If yes, what \_\_\_\_\_
3. Are you currently taking any medications? Yes/No. If yes, names and dosages: \_\_\_\_\_
4. Are you aware of having an allergic or adverse reaction to any medication or substance? ..... Yes/No  
 (please note in Medical Alerts)
5. Have you been a patient in the hospital in the last five years? ..... Yes/No
6. Indicate which of the following you have had or have presently. Circle Yes or No to each item.

Aids .....	Yes/No	Congenital Heart Dis .....	Yes/No	Latex Sensitivity.....	Yes/No
Allergies/Hive (medical alert) .....	Yes/No	Contacts.....	Yes/No	Liver Disease .....	Yes/No
Anemia .....	Yes/No	Cortizone Meds.....	Yes/No	Mitral Valve Prolapse.....	Yes/No
Anxiety .....	Yes/No	Diabetes .....	Yes/No	Neurological Disorder.....	Yes/No
Anxious/Nervous .....	Yes/No	Diet (special restrictions) .....	Yes/No	Pacemaker.....	Yes/No
Artificial Heart Valve .....	Yes/No	Dizziness/Fainting .....	Yes/No	Penicillin Allergy .....	Yes/No
Artificial Joints .....	Yes/No	Emphysema .....	Yes/No	Psychiatric/Psychological Care ..	Yes/No
Arthritis/Rheumatism .....	Yes/No	Epilepsy .....	Yes/No	Premed before Treatment .....	Yes/No
Aspirin Allergy .....	Yes/No	Glaucoma .....	Yes/No	Radiation Tx .....	Yes/No
Asthma .....	Yes/No	Hay Fever.....	Yes/No	Rheumatic Fever.....	Yes/No
Back Problems .....	Yes/No	Head Injury .....	Yes/No	Sickle cell Anemia.....	Yes/No
Birth Control Pills .....	Yes/No	Heart (attack, disease, surgery) ..	Yes/No	Sinus Problems .....	Yes/No
Blood Transfusion .....	Yes/No	Heart Murmur .....	Yes/No	Stroke .....	Yes/No
Bruise Easily .....	Yes/No	HIV positive .....	Yes/No	Sulfur Allergy .....	Yes/No
Cancer .....	Yes/No	Hemophilia .....	Yes/No	Swollen Ankles.....	Yes/No
Chemotherapy .....	Yes/No	Hepatitis A or B .....	Yes/No	Thyroid Problem .....	Yes/No
Chest Pain .....	Yes/No	High Blood Pressure .....	Yes/No	Tuberculosis .....	Yes/No
Chronic Cough .....	Yes/No	Jaundice.....	Yes/No	Tumors/Cysts .....	Yes/No
Codeine Allergy .....	Yes/No	Kidney Disorder .....	Yes/No	Ulcer .....	Yes/No
Cold Sores .....	Yes/No			Veneral Disease .....	Yes/No

7. Do you use tobacco products? Yes/No If Yes, what? \_\_\_\_\_
8. Do you sleep with more than two pillows? \_\_\_\_\_
9. Have you lost or gained more than 10 pounds in the past year? \_\_\_\_\_
10. Do you have or have you had any condition, disease or problem not listed? \_\_\_\_\_
11. Women -- Are you pregnant? \_\_\_\_\_ Months \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking birth control pills? \_\_\_\_\_

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Medical History Update	
(initial and date)	(initial and date)

*(Please complete the reverse side)*

Dental Health

When was your last dental visit? \_\_\_\_\_

How often do you see your dentist? \_\_\_\_\_

Are you having any dental problems now that require immediate attention? \_\_\_\_\_

Do any of the following cause you tooth discomfort? Hot \_\_\_\_\_ Cold \_\_\_\_\_ Sweets \_\_\_\_\_ Chewing \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

Do your gums bleed? \_\_\_\_\_ Feel swollen or tender? \_\_\_\_\_

Have you ever had periodontal treatment? \_\_\_\_\_

Do you clinch or grind your teeth? \_\_\_\_\_

Do your jaws feel tired or ache? \_\_\_\_\_ Click or pop? \_\_\_\_\_

Can you comfortably chew on both sides of your mouth? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_ Earaches? \_\_\_\_\_ Neck Aches? \_\_\_\_\_

Have you ever had orthodontic treatment? (Braces) \_\_\_\_\_

Do you lose or break fillings often? \_\_\_\_\_ Have cracked teeth? \_\_\_\_\_ Have cavities often \_\_\_\_\_

Do you have any noticeable wear on your teeth? \_\_\_\_\_ Food traps? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Have they been replaced? \_\_\_\_\_ How? \_\_\_\_\_

Are the replacements comfortable? \_\_\_\_\_

How do you feel about the appearance of your smile? \_\_\_\_\_

Have you ever had any cosmetic dentistry done to improve your smile? \_\_\_\_\_

If yes, are you pleased with the result? \_\_\_\_\_ Please comment? \_\_\_\_\_

Have you ever had any unpleasant dental experiences? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*(Please Complete the reverse side)*