Premier Dental Care of Buckhead

MAKING SMILES...ONE PATIENT AT A TIME

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. First Name_____ M.I.___ Last Name_____

Preferred Name _____ Birthdate _____ SSN _____

Address_____ City _____ State_____ Zip_____

Home (_____)_____ Cell (_____)_____ Work (_____)_____

Email _____ How would you like your appointments confirmed?
◯ Phone Call ◯ Text ◯ Email (check all that apply)

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

Emergency Contact_____ Relationship _____ Phone Number _____

Are you currently under the care of a physician? ◯ Yes ◯ No Name _____ Number_____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ◯ Yes ◯ No
If so, please list **all**, including vitamins, natural or homeopathic products:

_____

Are you taking any blood thinners? (Pradaxa, Coumadin, Plavix etc.) ◯ Yes ◯ No
If yes, please list

_____

Have you had an orthopedic total joint (hip, knee, elbow) replacement? ◯ Yes ◯ No
Were there any complications? ◯ Yes ◯ No
If yes, please explain _____Procedure Date _____
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? ◯ Yes ◯ No
If yes, what do you pre-medicate with? _____

Women Only: Are you pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking birth control or hormonal replacement? ◯ Yes ◯ No

Dental Information

Do your gums bleed when you brush or floss?	◯ Yes ◯ No	Do you have earaches or neck pains?	◯ Yes ◯ No
Are your teeth sensitive to cold, hot, sweets or pressure?	◯ Yes ◯ No	So you have any clicking, popping or discomfort in the jaw?	◯ Yes ◯ No
Does food catch between your teeth?	◯ Yes ◯ No	Do you brux or grind your teeth?	◯ Yes ◯ No
Is your mouth dry?	◯ Yes ◯ No	Do you have sores or ulcers in your mouth?	◯ Yes ◯ No
Have you had any periodontal (gum) treatment?	◯ Yes ◯ No	Do you wear dentures or partials?	◯ Yes ◯ No
Have you ever had orthodontic (braces) treatment?	◯ Yes ◯ No	Do you participate in active recreational activities?	◯ Yes ◯ No
Have you had any problems associated with previous dental treatment?	◯ Yes ◯ No	Have you ever had a serious injury to your head or mouth?	◯ Yes ◯ No
Is your home water supply fluoridated?	◯ Yes ◯ No	Date of your last dental exam:	_____
Do you drink bottled or filtered water?	◯ Yes ◯ No	What was done at that time?	_____
Are you experiencing dental pain or discomfort?	◯ Yes ◯ No	Date of your last dental x-rays:	_____

What is the reason for your dental visit today? _____

How do you feel about your smile?_____
When was your last dental visit? _____ Reason for visit? _____ Last Dental Cleaning? _____

Medical History

Allergies – Are you allergic to or have you had a reaction to:

Local anesthetics	◯ Yes ◯ No	Metals	◯ Yes ◯ No
Aspirin	◯ Yes ◯ No	Latex (rubber)	◯ Yes ◯ No
Penicillin or other antibiotics	◯ Yes ◯ No	Iodine	◯ Yes ◯ No
Barbiturates, sedatives or sleeping pills	◯ Yes ◯ No	Hay Fever/Seasonal	◯ Yes ◯ No
Sulfa drugs	◯ Yes ◯ No	Botox (Botulinum toxin)/Juvederm	◯ Yes ◯ No
Codeine or other narcotics	◯ Yes ◯ No	Tetracycline	◯ Yes ◯ No
Erythromycin	◯ Yes ◯ No	Other: _____	◯ Yes ◯ No

Have you ever had Botox or Juvederm? ◯ Yes ◯ No Are you interested in learning more about Botox or Juvederm? ◯ Yes ◯ No

Indicate which of the following you have had, or have at present:

Cardiovascular disease	◯ Yes ◯ No	AIDS or HIV infection	◯ Yes ◯ No	Thyroid problem	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Arteriosclerosis	◯ Yes ◯ No	Autoimmune disease	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Congestive heart failure	◯ Yes ◯ No	Rheumatoid arthritis	◯ Yes ◯ No	Hepatitis, jaundice or liver disease	◯ Yes ◯ No
Damaged heart valves	◯ Yes ◯ No	Lupus	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No
Heart attack	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting spells or seizures	◯ Yes ◯ No
Heart murmur	◯ Yes ◯ No	Lung disease	◯ Yes ◯ No	Neurological disorders	◯ Yes ◯ No
Low blood pressure	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	If yes, specify_____	
High blood pressure	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No	Sleep disorder	◯ Yes ◯ No
Artificial (prosthetic) heart valve	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Mental health disorder	◯ Yes ◯ No
				If yes, specify_____	
Previous infective endocarditis	◯ Yes ◯ No	Cancer/Chemotherapy / Radiation treatment	◯ Yes ◯ No	Reflux/persistent heartburn	◯ Yes ◯ No
Congenial heart disease (CHD)	◯ Yes ◯ No	Tumor(s)	◯ Yes ◯ No	Recurrent infections	◯ Yes ◯ No
Mitral valve prolapse	◯ Yes ◯ No	Chest pain	◯ Yes ◯ No	Contagious diseases	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No	Diabetes Type 1 or 2	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Rheumatic fever	◯ Yes ◯ No	Excessive urination	◯ Yes ◯ No	Night Sweats	◯ Yes ◯ No
Rheumatic heart disease	◯ Yes ◯ No	Eating disorder	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Abnormal bleeding	◯ Yes ◯ No	Malnutrition	◯ Yes ◯ No	Persistent swollen glands in neck	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Gastrointestinal disease	◯ Yes ◯ No		
Blood transfusion	◯ Yes ◯ No	Pneumonia/Bronchitis	◯ Yes ◯ No	Severe headaches or migraines	◯ Yes ◯ No
Hemophilia	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Sexually transmitted disease	◯ Yes ◯ No
Sleep Apnea or Insomnia	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Bruise or bleed easily	◯ Yes ◯ No	Organ Transplant	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Blood disease/disorder	◯ Yes ◯ No	Swelling in ankles	◯ Yes ◯ No	Sickle Cell disease	◯ Yes ◯ No

Do you have any disease, condition or problem not listed above that you think I should know about? ◯ Yes ◯ No

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions; if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Premier Dental Care of Buckhead

MAKING SMILES...ONE PATIENT AT A TIME

Signature _____ Date _____

3580 Piedmont Road N.E., Suite 113 Atlanta, GA 30305