Adult Medical / Dental History

NORTH GWINNETT DENTAL CARE

Date:_____

Patient's Full Name_____**Nickname**_____

Why did you come to the dentist today? _____

Street Address_____

City_____**Zip**_____ **Patient's Main Telephone #** _____

Work Telephone # _____ **Cellular Telephone #**_____

Date of Birth_____/_____/_____ **Sex: M (__) F (__) Marital Status: Single(__) Married(__) Widowed(__) Divorced(__)**

Social Security Number:_____— _____— _____ **E mail Address (important)** _____

Occupation_____**Employer**_____

We provide free on-site child care for our patients. Do you anticipate using this service? Yes (___) or No(___)

Do you have any children? Yes (__) or No (__) Names and Ages of your children:

1) _____ **2)** _____ **3)** _____ **4)** _____ **5)** _____

In case of an emergency, whom should be notified?_____**Tel.#**_____

Name of Spouse (if applicable) _____**Spouse Work Phone/Cellular:**_____

Occupation of Spouse _____ **Employer** _____

Spouse's Date of Birth _____/_____/_____ **Spouse's Social Security Number** _____— _____—_____

Person responsible for account (if not yourself) _____

Whom may we thank for referring you ? (___)Sign on building (___)New Homeowner Letter (___)Letter// Flyer sent to you

(___)Website (___)Friend/Family/Employee (Name: _____**) (___)Other** _____

Do you have dental insurance that may cover any part of our professional services? Yes(___) No(___)

INSURANCE INFORMATION

Insured Party's Full Name_____**Social Security Number**_____—_____—_____

Relationship to Patient: Self(___) Spouse(__) Parent / Step Parent(__) Other (specify :_____**)**

Employer _____ **Insurance Company Name**_____

Ins. Address _____ **Ins Phone #**_____

Group Name_____ **Group Number**_____

Secondary Insurance (if applicable)

Secondary Insurance Insured's Name _____ **Social Security Number** _____—_____—_____

Relationship to Patient: Self(___) Spouse(__) Parent/Step Parent(__) Other (specify :_____**)**

Employer _____ **Insurance company Name__** _____

Ins. Address _____ **Ins Phone #** _____

Special Notes _____

Our dentists do not participate in any of the managed care dental plans (where you may only go to a dentist on a particular list). Traditional insurance is accepted and submitted on your behalf, but you are responsible for any charges your insurance does not cover at the time of service. If you do not have insurance, we have a membership plan that may make dental care more affordable. It provides two checkups per year and a fifteen percent discount off of all other dental treatment (except Botox, Fillers and Orthodontic care), for $30 per month or less (depending on size of your family). Please view our website www.SugarHillDentist.com or ask a team member for information.

Physician's Name _____**City** _____ **State** _____
Former Dentist's Name _____**City**_____ **State** _____
Why are you changing dentists?
_____
_____
When was the last time you had a check up and professional cleaning? _____ **x-rays?** _____
X-rays taken at your last visit? (__) FMX 18 x-rays (__) BWX 4 x-rays (__) Panorex 1 large x ray (__) Don't Know
Are you having pain today? Y(__) N(__) Please describe: _____
Are you apprehensive about dental treatment Y(__) N (__) If you are apprehensive, what of ? (be very specific)
_____**We offer sedation for dentistry - would you be interested?** _____
Have you been told to take an antibiotic before dental treatment? Y(__) N(__) Why? _____
Are you interested in straightening your teeth ? _____ **We offer traditional braces and INVISALIGN.**
Have you had your teeth bleached ? Y(__) N(__) Are you interested in whitening your teeth? _____
Are you happy with your smile? Y(__) N(__) If not, what would you change?_____
Do you smoke? Y(__) N(__) , Tobacco/snuff? Y(__) N(__) , Have you been told you have periodontal disease?Y(__)N(__)
Do your gums bleed when you brush? Y(__) N(__) Bleed when you floss? Y(__) N(__)
Do you have pain when you open and close your mouth? Y(__) N(__) , Have TMJ syndrome?Y(__) N(__)
Have you ever had any serious problems with previous dental work? Y(__) N(__) Describe: _____
Are you allergic to any of the following

Codeine Y(_)N(_) / Dental Anesthetics Y(_) N(_) / Penicillin Y(_) N(_) / Clindamycin Y(_) N(_) / Latex Y(_) N(_)

Have you ever had any of the following diseases or medical problems? Please Circle Y or N

Y N Heart trouble/ attack
Y N Heart murmur as a child
Y N Heart murmur currently
Y N Heart Pacemaker
Y N Mitral valve prolapse
Y N Artificial heart valve
Y N Artificial joint
Y N Hepatitis
Y N HIV + / AIDS / ARC
Y N Tuberculosis
Y N Drug/Alcohol abuse

Y N Stroke
Y N Diabetes
Y N Fainting or dizzy spells
Y N Emphysema
Y N Psychiatric treatment
Y N Anemia
Y N Blood transfusion
Y N Ulcers
Y N Epilepsy or seizures
Y N High blood pressure
Y N Cortisone (steroid) medicine

Y N Sinus Trouble
Y N Rheumatic fever
Y N Jaundice
Y N Chemotherapy
Y N Radiation treatment
Y N Cancer (what kind?)
Y N _____
Y N Bulimia
Y N Asthma
Y N Arthritis
Y N Fever blisters

Please list any other drugs or metals that you are allergic to:
_____
Please list all medications/herbs/over the counter drugs you are taking and *why* you are taking them.
Please list any other medical condition/ congenital abnormalities that you have been or are being treated for:

1)_____ **2)**_____ **3)** _____
For_____ **For**_____ **For**_____

4)_____ **5)**_____ **6)**_____
For_____ **For**_____ **For**_____

_____
Are you pregnant (__)Y (__)N (__)Possibly Are you nursing a baby? (__)Y (__)N

I affirm that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.

Signature of patient: _____**Date**_____