

North Georgia Dentures and Implants

Patient History Information

****WE DO NOT ACCEPT DENTAL or MEDICAL INSURANCE****

Name: _____

Today Date: _____ Sex: M / F Date of Birth: ____/____/____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone# _____

Work Phone: _____ Cell. Phone: _____

What is the reason for today's visit? _____

How did you find out about our office? _____

Who is your present dentist? _____

Are you taking or have you ever taken prescription medication for Osteoporosis (bone loss)? Y/N
If yes, please specify: _____

OUR PAYMENT POLICY

We gladly accept payment by CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS.

WE DO NOT ACCEPT CHECKS.

WE DO NOT FILE INSURANCE, BUT WILL GLADLY PRINT AN INSURANCE FORM FOR
YOU TO FILE.

HEALTH HISTORY

	YES	NO						
1. Are you having pain or discomfort at this time?	<input type="checkbox"/>	<input type="checkbox"/>						
2. Do you feel very nervous about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>						
3. Have you ever had a bad experience in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>						
4. Have you ever been a patient in the hospital during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>						
5. Have you been under the care of a medical doctor during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>						
Physician's Name _____ Phone # _____								
6. Are you taking bisphosphonates? (medicine for bones) <input type="checkbox"/> Yes <input type="checkbox"/> No (example: Fosamax, Boniva, Actonel, Reclast)								
Women:								
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what month? _____ Are you taking birth control pills?	Yes	No						
	<input type="checkbox"/>	<input type="checkbox"/>						
7. Have you taken any medicine or drugs during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>						
Are you now taking any medication, drugs, or pills?	<input type="checkbox"/>	<input type="checkbox"/>						
If yes, please list: _____								
8. Are you allergic or have you reacted adversely to any of the following medications?	<input type="checkbox"/>	<input type="checkbox"/>						
Please check all that apply:								
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Valium						
<input type="checkbox"/> Darvon	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Scopolamine						
<input type="checkbox"/> Codeine	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Penicillin						
<input type="checkbox"/> Demerol	<input type="checkbox"/> Percodan	<input type="checkbox"/> Other Antibiotics						
		<input type="checkbox"/> Local Anesthetic (Novocain or Xylocaine)						
		<input type="checkbox"/> Sleeping Pills						
		<input type="checkbox"/> (Nembutal/Seconal)						
9. Are you aware of being allergic to any other medications or substance?	<input type="checkbox"/>	<input type="checkbox"/>						
If yes, please list: _____								
10. Have you had or have at present - Please check Yes or No:								
	YES	NO		YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive and/or AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (serum)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Veneral Disease (Syphilis, Gonorrhea)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or Cobalt treatment	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (Hip, Knee)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Snoring or Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily
11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	<input type="checkbox"/>	<input type="checkbox"/>						
12. Have you lost or gained more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>						
13. Are you currently taking any diet medication (Herbal, Phenfen, Redux)?	<input type="checkbox"/>	<input type="checkbox"/>						
14. Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>						
15. Has your medical doctor ever said you have a cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>						
16. Do you smoke cigarettes, cigars or pipe tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>						
17. Do you use smokeless tobacco products (chewing tobacco, snuff)?	<input type="checkbox"/>	<input type="checkbox"/>						
18. Do you have any disease, condition, or problem not listed?	<input type="checkbox"/>	<input type="checkbox"/>						

Antibiotics may interfere with the action of Oral Contraceptives (OC). If you use OC and are prescribed an antibiotic, it is recommended that you use additional contraceptive precautions while taking the medicine and for the following seven (7) days. I certify that the information provided is true and accurate to the best of my knowledge.

Signature of Patient (Parent or Guardian if minor)

Date