2125 Post Oak Tritt Rd. Marietta, GA Phone: 770.977.9090 Fax: 770.977.9058

Medical History

DENNY FAMILY DENTISTRY

1. Are you under medical treatment now? Please list: ____________________.

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Please list:

____________________.

3. Are you taking any medications including non-prescription medicine? Please list:

____________________.

4. Have you ever taken Fen-Phen/Redux? ____________________.

5. Do you chew Tobacco? __________ Do you smoke Cigarettes? __________ Other __________.

6. Do you use controlled substances? ____________________.

7. Check if you have or have had any of the following:

- ❒ Aids/HIV positive
- ❒ Anemia
- ❒ Arthritis
- ❒ Artificial joints
- ❒ Asthma
- ❒ Blood Disease
- ❒ Cancer
- ❒ Diabetes
- ❒ Dizziness
- ❒ Epilepsy
- ❒ Excessive Bleeding
- ❒ Fainting
- ❒ Glaucoma
- ❒ Head Injuries
- ❒ Heart Murmur/ Mitro Valve Prolapse
- ❒ Hepatitis A B C
- ❒ High Blood Pressure
- ❒ Jaundice
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Mental Disorders
- ❒ Nervousness/Depression
- ❒ Pacemaker
- ❒ Radiation Treatment
- ❒ Respiratory Problems
- ❒ Rheumatic Fever
- ❒ Rheumatism
- ❒ Sinus Problems
- ❒ Stomach Problems
- ❒ Stroke
- ❒ Tuberculosis
- ❒ Tumors
- ❒ Other __________.

8. Check if you are allergic to or have had any reactions to the following:

- ❒ Aspirin
- ❒ Latex
- ❒ Percodan
- ❒ Codeine
- ❒ Nitrous Oxide
- ❒ Seasonal
- ❒ Erythromycin
- ❒ Penicillin
- ❒ Sulfa Drugs
- ❒ Valium
- ❒ Local Anesthetics
- ❒ Other __________.

Are you pregnant or think you may become pregnant?______ Due Date _________ Are you nursing?_______ Are you taking contraceptives? _______.

Dental History:

Please check any of the following that apply to you:

- ❒ Sensitivity (hot, cold, sweets, pressure
- ❒ Discomfort when chewing
- ❒ Headaches, ear aches, neck pain, Jaw joint pain
- ❒ Teeth or fillings breaking
- ❒ Grinding clenching teeth
- ❒ Bleeding, swollen or irritated gums
- ❒ Loose, chipped or shifting teeth
- ❒ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ❒ Dentures
- ❒ Partial Dentures
- ❒ Braces

How long has it been since your last cleaning?

Less than 1 yr 1-2yrs 3-5yrs over 5yrs

What is the most important thing about your visit today? ____________________.

What would you like to do to improve your smile?

- ❒ Whiten
- ❒ Straighten
- ❒ Close Spaces
- ❒ Replace silver fillings with tooth colored fillings
- ❒ Repair chipped teeth
- ❒ Replace missing teeth
- ❒ Replace old crowns that don't match other teeth

Name of previous dentist ____________________ Phone number ____________________ City & State __________.

Why did you leave your previous dentist? ____________________.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any services rendered. I have read all the information on this form and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature ____________________ Date __________