MARBLE HILL DENTISTRY

NAME: _____ Tel: 770-893-1904

ARTISTRY • INTEGRITY • PASSION

171 FOOTHILLS PKWY STE 209
MARBLE HILL, GA 30148

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____ How long? _____
☐Y☐N☐ Drink Alcohol?_____ How many a day?_____
Y ☐N Recreational Drugs?_____ What kind/how long/how much?_____
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*
☐Y☐N **Is pre-medication required before dental visits due to heart condition or artificial joint?**

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant/trying? Due Date: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐CHEMOTHERAPY	☐HEART DISEASE	☐ RESPIRATORY DISEASE
☐AIDS/HIV	☐CIRCULATORY PROBLEMS	☐HEART MURMUR	☐ RHEUMATIC/SCARLET FEVER
☐ANEMIA	☐CORTISONE TREATMENTS	☐HEPATITIS A/B/C	☐ SHORTNESS OF BREATH
☐ANOREXIA/BULIMIA	☐COUGH, PERSISTENT	☐HIGH BLOOD PRESSURE	☐ SINUS PROBLEMS
☐ANXIETY	☐DIABETES	☐KIDNEY DISEASE	☐ STROKE
☐ARTIFICIAL HEART VALVE	☐DIZZINESS/FAINTING	☐ LIVER DISEASE	☐ SURGICAL IMPLANT
☐ARTIFICIAL JOINTS	☐EPILEPSY/SEIZURES	☐ MITRAL VALVE PROLAPSE	☐ THYROID CONDITION
☐ARTHRITIS, RHEUMATISM	☐FOOD ALLERGIES	☐ NERVOUS PROBLEMS	☐ TUBERCULOSIS
☐ASTHMA	☐FREQUENT HEADACHES	☐ PACEMAKER	☐ ULCERS/COLITIS
☐BLOOD DISEASE	☐GLAUCOMA	☐ PSYCHIATRIC TREATMENT	☐ VENEREAL DISEASE
☐CANCER	☐HEARING PROBLEMS	☐ RADIATION	
☐CHEMICAL DEPENDENCY	☐HEART ATTACK/SURGERY	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	
☐OTHER – PLEASE LIST:		WHAT IS THE REACTION?		

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced? If yes, when?_____

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Any concerns about the appearance of your teeth?_____ Color?_____ Size?_____ Crowding/Spacing?_____

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

Have you ever used a bisphosphonate medication such as Fosamax, Actonel, Atelvia, Didronel and Boniva? ☐Y☐N

Have you ever taken Fen-Phen/Redux? ☐Y☐N Have you ever had a blood transfusion? ☐Y☐N

If yes, please describe and give approximate dates:_____

Any additional concerns/comments?

_____