Dental Partners of Southwest Georgia

Name_____ DOB_____ Age____ Sex____ SS#_____
Address_____ City _____ State ____ Zip _____
Home #_____ Work # _____ Cell Phone # _____
Email address_____
Whom may we thank for referring you?_____
Employer _____ WK #_____

Spouse/Parent/ Guardian- Circle One
Name_____ SS#_____ DOB _____ Phone# _____
Employer _____ Address _____WK# _____
Primary Insurance _____ Secondary Insurance_____

Your Current Medical History
Personal Physician: Name_____ Phone # _____
Are you currently under the care of a physician? Yes____ No ____ Explain_____
Recent Hospitalization_____
Do you smoke or use tobacco products of any form? Yes____ No____
Have you had any metal rods, pins, or implants? Yes ____ No ____
Are you taking any prescriptions or over-the-counter drugs? Yes ____ No ____
Please list each one_____
Are you allergic to any drugs/materials? _____

Your Current Dental Health is Good_____ Fair_____ Poor_____
Date of last dental visit _____ Procedure _____
Do your gums bleed? Yes _____ No _____Have you ever had gum disease? Yes ___ No __
Are your teeth sensitive to heat, cold, or anything else? _____
In case of emergency call Name_____ Phone # _____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Epilepsy	Y N Mitral Valve Prolapse
Y N AIDS	Y N Fainting Spells	Y N Pacemaker
Y N Alcohol/Drug Abuse	Y N Frequent Headaches	Y N Psychiatric Problems
Y N Anemia	Y N Glaucoma	Y N Radiation Treatments
Y N Arthritis	Y N Hay Fever	Y N Rheumatic/Scarlet Fever
Y N Artificial Bones/Joints	Y N Heart Attack/Surgery	Y N Seizures
Y N Artificial Valves	Y N Heart Murmur	Y N Shingles
Y N Asthma	Y N Hemophilia	Y N Sickle Cell Diseases
Y N Blood Transfusion	Y N Hepatitis/Jaundice	Y N Sinus Problems
Y N Cancer/Chemotherapy	Y N Herpes/Fever Blisters	Y N Stroke
Y N Colitis	Y N High Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N HIV	Y N Tuberculosis (TB)
Y N Diabetes	Y N Kidney Problems	Y N Ulcers
Y N Difficulty Breathing	Y N Liver Disease	Y N Sexually Transmitted Disease
Y N Emphysema	Y N Low Blood Pressure	YN Heart Disease
YN Recent weight loss	YN Other_____	YN Are you Pregnant

Signature_____ Date _____