Patient Information

The Teeth Doctor
6025 Cumming Highway, Suite 610
Sugar Hill, GA 30518

CONTACT INFORMATION

Mr. / Mrs. / Ms. Miss / Dr.

Name: _____ Preferred Name: _____
(First) (Last) (M.I.)
Date of Birth: _____ Gender: Male / Female

Home Phone Number: _____ Cell Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone Number: _____

Referred by: (circle one) Google Yelp ZocDoc Walk-in/Drive-by Mailer Other: _____

INSURANCE INFORMATION

Dental Insurance Company: _____ Member ID #_____

Are you the Subscriber? Yes / No If no, who? _____ Relation to Subscriber: _____

Subscriber DOB: _____ Subscriber Social Security Number: _____

Employer: _____ Position: _____

MEDICAL HISTORY

Are you under a physician's care now?	Yes / No
Are you allergic to penicillin?	Yes / No
Are you allergic to latex?	Yes / No
Do you have any artificial joints?	Yes / No
Do you have an artificial heart valve?	Yes / No
Were you born with a congenital heart defect?	Yes / No
Have you ever had endocarditis?	Yes / No
Have you ever taken bisphosphonates (ex. Fosamax)?	Yes / No
Are you taking any blood thinners (ex. Aspirin)?	Yes / No
Do you smoke or use tobacco?	Yes / No
FEMALES ONLY: Are you pregnant?	Yes / No
FEMALES ONLY: Are you taking oral contraceptives?	Yes / No

Please list any other medical conditions not listed

_____
_____
_____
_____

Please list any current medications or supplements

_____
_____
_____

Please list any allergies

_____
_____
_____
_____

Do you have a history of the following?

☐ AIDS/ HIV	☐ Cancer	☐ Heart Attack	☐ Liver Problems
☐ Alzheimer's Disease	☐ Chemotherapy	☐ Hepatitis	☐ Osteoporosis
☐ Anemia	☐ Chest Pain	☐ Herpes	☐ Pacemaker
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Radiation
☐ Blood Disorders	☐ Epilepsy	☐ High Cholesterol	☐ Sinus Problems
☐ Back Problems	☐ Excessive Bleeding	☐ Kidney Problems	☐ Stroke

DENTAL HISTORY

Previous Dentist's Name: _____

Date of last dental visit: _____

How often do you brush your teeth? _____ per day

How often do you floss your teeth? _____ per day

Are you experiencing any pain or discomfort?	Yes / No	Do you experience jaw pain?	Yes / No
Have you ever had gum treatments?	Yes / No	Do you wear a night guard?	Yes / No
Do your gums bleed?	Yes / No	Do you experience dry mouth?	Yes / No

Would you like to improve your smile? Yes / No

If yes, how would you like to improve your smile? _____

By signing this form below, I acknowledge that the information on this page is correct to the best of my knowledge. I also agree to notify the office of any changes to the information provided above.

Patient *or* Parent / Guardian Signature _____ Date _____