North Road Famly Dental

2175 North Road SW, Snellville, GA 30078 • Phone 770.972.2000 • Fax 770.979.5000

Please circle (Y)YES or (N)NO to each question.

Patient's Name _____ Birthdate_____ Today's Date _____

Date of Last Dental Exam _____ Name of Dental Office _____

Do you have a medical condition that requires antibiotic premedication? **Y N**

Have you ever taken bisphosphonates, such as, Fosamax, Boniva, Actonel, Reclast? **Y N**

Are you presently taking any medicine(s) including non-prescription? **Y N**

If yes, please list:_____

Are you allergic to, or had a bad reaction to:

Local anesthetic (Novocaine, etc.)	**Y N**	Codeine or other pain killers	**Y N**
Penicillin, Amoxicillin, Erythromicin, Cephalosporins or other antibiotics	**Y N**	Latex or other rubber products	**Y N**
		Other allergies or reactions	**Y N**
Barbiturates, sedatives, etc.	**Y N**	If yes, please list: _____	
Aspirin or Ibuprophen	**Y N**	_____	

Indicate which of the following you have had or have at present:

Heart Failure	**Y N**	Drug Addiction	**Y N**	Chemotherapy	**Y N**
Congestive Heart Failure	**Y N**	Stroke	**Y N**	Hepatitis	**Y N**
Heart Disease or Attack	**Y N**	Artificial Joints (hip, knee, etc.)	**Y N**	If yes, what type? _____	
Angina Pectoris	**Y N**	If yes, when? _____		AIDS	**Y N**
Heart Murmur	**Y N**	Kidney Trouble	**Y N**	HIV Positive	**Y N**
Artificial Heart Valve	**Y N**	Liver Trouble	**Y N**	Hemophilia	**Y N**
High Blood Pressure	**Y N**	Diabetes	**Y N**	Tobacco Use (smoke / chew)	**Y N**
Mitral Valve Prolapse	**Y N**	Emphysema	**Y N**	Epilepsy or Seizures	**Y N**
Heart Pacemaker	**Y N**	Tuberculosis	**Y N**	Fainting or Dizzy Spells	**Y N**
Rheumatic Fever	**Y N**	Cancer/Tumor	**Y N**	Do you take blood thinners?	**Y N**
Arthritis	**Y N**	Radiation Therapy	**Y N**		

Do you have, or have you had, any disease, condition or problem not listed above? **Y N**

If yes, please list: _____

Can you recline flat or almost flat? **Y N**

Date of Last Physical Exam _____ Present Physician's Name _____ Phone _____

For Women Only

Are you pregnant? **Y N** If yes, due date: _____ Are you nursing? **Y N**

Are you taking birth control pills? **Y N**

Antibiotics may cause birth control pills to be ineffective. Please contact your physician with questions.

CONSENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you.

I have answered all questions truthfully and to the best of my knowledge.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit.

I also understand the use of anesthetic agents embodies a certain risk.

Patient, Parent or Responsible Party Signature _____ Relationship to Patient_____

Dr. or Staff Initials _____ Today's Date _____

PATIENT HEALTH HISTORY UPDATE

Patient's Name ____ Date of Birth__________________

Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________

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Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________

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Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________

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Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________

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Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________

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Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________

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Changes since my last visit: ____

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Patient's Signature ____________________________ Date _____________ Dr. or Staff Initials__________