GWINNETTDENTAL
IMPLANT CENTER

NEW PATIENT
Medical History Form

ABOUT YOU

Today's Date:

Email Address _____

Name _____

Prefer to be called _____ ☐ Male ☐ Female

Birthdate _____ Age: _____

Social Security # _____ DL # _____

Home Address _____

City _____ Zip _____

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Extension _____

Employer _____

Employer Address _____

City _____ Zip _____

How long there? _____ Occupation _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Dentist _____

Person Responsible for Account _____

Spouse Information

Spouse Name _____

Employer _____

Work Phone _____ Extension _____

Social Security Number _____

Birthdate _____ DL # _____

Relative or Friend not living with you:

Name _____ Relation _____

Work Phone _____ Home Phone _____

INSURANCE

Primary Insurance

Dental Coverage ☐ Yes ☐ No

Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Insurance Co. Phone (_____) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate _____ ID # _____

Insured's Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Secondary Insurance

Secondary Dental Coverage ☐ Yes ☐ No

Insurance Co. _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone (_____) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate _____ ID # _____

Insured's Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to **Dr. M. Forest Butler** of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or exam rendered, to my insurance company.

Signature _____ Date _____

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MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # (____) _____ Date of last visit? _____

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list: _____

_____

Have you ever taken Fosamax or other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

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

Y	N	Abnormal bleeding/hemophilia	Y	N	Herpes / fever blisters
Y	N	AIDS	Y	N	High blood pressure
Y	N	Alcohol / drug abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for any reason
Y	N	Arthritis	Y	N	Kidney problems
Y	N	Artificial bones / joints / valves	Y	N	Liver disease
Y	N	Asthma	Y	N	Low blood pressure
Y	N	Blood tranfusion	Y	N	Lupus
Y	N	Cancer / chemotherapy	Y	N	Mitral valve prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital heart defect	Y	N	Psychiatric problems
Y	N	Diabetes	Y	N	Radiation treatment
Y	N	Difficulty breathing	Y	N	Rheumatic / scarlet fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle cell disease / traits
Y	N	Frequent headaches	Y	N	Sinus problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay fever	Y	N	Thyroid problems
Y	N	Heart attack / surgery	Y	N	Tuberculosis (TB)
Y	N	Heart murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal disease

Please list any serious medical condition(s) you have experienced:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry / metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/materials you are allergic to: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever had a serious or difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of **Dr. M. Forest Butler** of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____ Date _____

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials _____ Date _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N

If yes, please explain:

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Has there been any change in your health status since your last visit? Y N

If yes, please explain:

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.