

# Welcome

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.



*Atlanta Aesthetic & Laser Dentistry*

## About You

Name: \_\_\_\_\_

I like to be called: \_\_\_\_\_

Home address: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed

Spouse's name: \_\_\_\_\_

In case of an emergency, is there someone we can call?

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Whom can we thank for referring you? \_\_\_\_\_

## Dental History

Why have you come to see us today?  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe the condition of your teeth and gums?

Good  Fair  Poor

Are you currently in pain or discomfort with your teeth and gums?

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

Floss your teeth? \_\_\_\_\_

Do your gums bleed when you brush?

Floss?

Have you ever experienced pain in your jaw joint?

Do you grind your teeth?

Have you ever been treated for TMJ symptoms?

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

## Health History

Have you been hospitalized in the last 5 years?

If yes, reason: \_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving care?

If yes, nature of care: \_\_\_\_\_  
\_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Email: \_\_\_\_\_

Beeper: \_\_\_\_\_

Cell phone: \_\_\_\_\_

When is the best time to communicate with you? \_\_\_\_\_

and Where? \_\_\_\_\_

Special interests or hobbies: \_\_\_\_\_  
\_\_\_\_\_

Many patients consult us for a second opinion.

Have you seen another dentist for your dental needs?

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

The date of your last dental visit: \_\_\_\_\_

Previous dentist's name: \_\_\_\_\_

If you could wave a magic wand, and change anything you about the appearance of your smile, what would you like to do?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you could easily and safely whiten your teeth, would you be interested?

Date of last health care exam: \_\_\_\_\_

What was this exam for? \_\_\_\_\_  
\_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

For the following questions please check all that apply. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

- |   |   |
|---|---|
| <input type="checkbox"/> Heart murmur (mitral valve prolapse)       | <input type="checkbox"/> Psychosis                          |
| <input type="checkbox"/> Anemia                                     | <input type="checkbox"/> Sore/enlarged lymph nodes          |
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Previous biopsies                  |
| <input type="checkbox"/> Epilepsy                                   | <input type="checkbox"/> Slow-healing mouth sores           |
| <input type="checkbox"/> Hepatitis, any form                        | <input type="checkbox"/> Other Infections                   |
| <input type="checkbox"/> Rheumatic fever                            | <input type="checkbox"/> Recurrent Illnesses                |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Joint Replacement                  |
| <input type="checkbox"/> HIV positive or AIDS related complications | <input type="checkbox"/> Glaucoma                           |
| <input type="checkbox"/> Emphysema or other respiratory illnesses   | <input type="checkbox"/> Abnormal bleeding from a cut       |
| <input type="checkbox"/> Abnormal heart condition                   | <input type="checkbox"/> Liver disease (including jaundice) |
| <input type="checkbox"/> Kidney disease                             | <input type="checkbox"/> Unintentional weight loss/gain     |
| <input type="checkbox"/> Heart (surgery, disease, attack)           | <input type="checkbox"/> Latex sensitivity                  |
| <input type="checkbox"/> Venereal disease                           | <input type="checkbox"/> Osteoporosis                       |

- Are you required to Pre-Medicate before dental treatment?
- Abnormal blood pressure?  
If yes, what is it usually: S \_\_\_\_\_/D \_\_\_\_\_ (Example: 120/80)

- Are you allergic or have you had a reaction to:
- Local anesthetic
  - Penicillin or other antibiotics
  - Aspirin
  - Codeine, valium or other sedatives
  - Other \_\_\_\_\_

- Women:
- Are you pregnant?
  - If no, are you planning a pregnancy in the near future?
  - Are you a nursing mother?
  - Are you taking birth control pills?

- Are you a smoker?  
If yes, how much do you smoke per day? \_\_\_\_\_

- Please list any medications you are currently taking:
1. \_\_\_\_\_
  3. \_\_\_\_\_
  5. \_\_\_\_\_

2. \_\_\_\_\_
4. \_\_\_\_\_
6. \_\_\_\_\_

- Are you taking Tagamet (Cimetidine)?  
If yes, how often? \_\_\_\_\_
- Are you taking or have you ever taken Fosamax?
- Do you take antacids? If yes, how often? \_\_\_\_\_
- Are you taking any herbal supplements/medicines?  
If yes, which ones? \_\_\_\_\_  
\_\_\_\_\_

- Diet:
- Restricted Diet \_\_\_\_\_
- How many meals a day \_\_\_\_\_
- Food Allergies \_\_\_\_\_
- Sugar in your diet:  None  Slight  Moderate  High

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor or his staff to use any photos they make take to be used for lecturing or education purposes.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date