SouthernSmiles
FAMILY DENTISTRY

475 BILL KENNEDY WAY, SUITE D AND E
ATLANTA, GA 30316
Ⓟ 404.622.0622 Ⓕ 404.622.0624

**Patient Information**

Patient Name:______________________________________________ Date:__________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________________________

Social Security #: ____________ Birth Date: __________E-Mail: ____________________________

Phone (Home): _____________ Mobil/Cell: ________________ (Work): ____________ Ext: _________

In case of Emergency, contact: Name _________________ Phone _____________ Relation ____________

Address: ____________________________________________________________________
Street Apartment #

______________________________________________________________________
City State Zip Code

**Health Information**

Previous Dentist: ______________________________________________________________

Date of Last Dental Visit: _________________________ Date of Last x-rays: _______________________

Reason for this visit: ____________________________________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies __________
__________________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chest Pain
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting

☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Defect
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease

☐ Lung Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse (MVP)
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due: ______________
☐ Prescribed Weight Loss Med
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke

☐ Tobacco Usage
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Antibiotics Allergy
☐ Codeine Allergy
☐ Latex Allergy
☐ Penicillin Allergy
☐ Other Anesthetic Allergy

OTHER:
☐ ___________
☐ ___________
☐ ___________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _______________________________________________________

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _______________________________________________________

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _______________________________________________________

Name of Physician: ______________________________________________ Phone: _____________

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _______________________________________________________

Are you taking any medications? Please List: ______________________________________________

______________________________________________________________________

What is your primary source of water? ☐ Well ☐ County
Do you pre-medicate for dental appointments? ☐ Yes ☐ No If so, why ___________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

______________________________________________________________ Date: ______________