CONYERS DENTURE AND IMPLANT CENTER

1916 Iris Drive, S.W.
Conyers, Georgia 30094
Office (770) 483-4469
Fax (770) 922-0401

Today's Date: _____

EXAMINATION and HEALTH HISTORY QUESTIONNAIRE

In order to aid in evaluating your dental health thoroughly and completely, please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

Patient Information

Name:_____D.O.B:_____SS#:_____

Marital Status: Single_____ Married_____ Divorced_____ Other_____ Minor_____

Responsible Party (if patient is a minor) _____Relationship_____

Address:_____ City/State/Zip:_____

Home Phone: _____Other: _____E-mail:_____

Place of Employment:_____Position:_____

Address:_____ City/State/Zip:_____

Work Phone #: _____Ext:_____

Name of Spouse:_____D.O.B:_____SS#:_____

Place of Employment:_____Position:_____

Address:_____ City/State/Zip:_____

Work Phone #: _____Ext:_____

Nearest Relative Not Living with You:_____

(Name, Address, City, State, Zip, Telephone #)

Who may we thank for referring you to us?_____

Referring Dentist:_____ Phone #:_____ How Long?_____

Name of Physician: _____Phone #:_____How Long?_____

Policy Holder Information

Name:_____D.O.B:_____SS#:_____

Place of Employment:_____ Address:_____

City/State/Zip:_____Work Phone #:_____

Insurance Carrier:_____ Phone #:_____

Health History **CIRCLE ONE**

1. Are you in good health?..... **YES** **NO**
2. Are you being treated by a physician now?..... **YES** **NO**
3. When was your last physical examination? _____
4. Are you currently taking any drugs or medication? (if so, please list below)…….. **YES** **NO**

   _____
5. Have you had excessive bleeding requiring special treatment?..... **YES** **NO**
6. Has anyone in you family ever had diabetes?..... **YES** **NO**

   If so, who?_____
7. Do you now have, or have ever had, any of the following? If yes, please indicate.

__Heart Disease	__Artificial Joints	__Anemia	__Epilepsy or Seizures
__Heart Attack	__Kidney Trouble	__Arthritis, Inflammatory	__Fainting or Dizziness
__Angina Pectoris	__Ulcers	__Arthritis, Rheumatoid	__Headaches, Migraines
__High Blood Pressure	__Tuberculosis (TB)	__A.I.D.S.	__Headaches, other
__Heart Surgery	__Hemophilia	__H.I.V. +	__Bruise easily
__Heart Pacemaker	__Emphysema	__Hepatitis A	__Bulimia/Anorexia
__Congenital Heart	__Asthma	(Infectious)	__Nervousness
Lesions	__Hay Fever	__Hepatitis B (serum)	__Psychiatric Treatment
__Heart Murmur	__Sinus Trouble	__Hepatitis C	__Cosmetic Surgery
__Mitral Valve Prolapse	__Diabetes	__Liver Disease	__Broken Jaw
__Rheumatic Fever	__Thyroid Disease	__Venereal Disease	__Pain in Jaw Joints
__Artificial Heart Valve	__Cancer	__Fever Blisters	__Snoring/Sleep Apnea
__Stroke	__Radiation Treatment	__Cold Sores	

8. Are you allergic or have you reacted adversely to any of the following medications? If yes, please indicate.

___Penicillin	___Aspirin	___Valium	___Tetracycline	___Erythromycin
___Darvon	___Nickel	___ Novocaine	___Codeine	___Fluoride
___Sulfa	___Latex	___Nitrous Oxide	___Xylocaine	

9. Are you aware of being allergic to any other medications or substances?..... **YES** **NO**

   If yes, please explain:_____

   _____
10. Do you have any reason to pre-medicate with antibiotics before a dental appointment?..... **YES** **NO**
11. Have you ever had a dependency on alcohol or drugs?..... **YES** **NO**
12. Have you ever had X-ray treatments for a tumor or skin disease?..... **YES** **NO**
13. Have you ever been treated for any type of skin disease?..... **YES** **NO**
14. Are your joints ever painful or swollen?..... **YES** **NO**
15. Do you get out of breath easily?..... **YES** **NO**
16. Has a physician ever said you had stomach trouble?..... **YES** **NO**
17. Are you considered a nervous person?..... **YES** **NO**
18. Do you smoke?..... **YES** **NO**

    If so, how many a day_____

FOR WOMEN ONLY

Are you pregnant?.....**YES** **NO**

Do you smoke?.....**YES** **NO**

Have you reached menopause?.....**YES** **NO**

Dental History

19. How long since your last dental examination?_____

20. Have you had orthodontic treatment?.....**YES** **NO**

21. Have you ever had Periodontal treatment?.....**YES** **NO**

22. What prompted you to seek Periodontal care at this time?_____

_____

23. Are you having pain in your mouth now?.....**YES** **NO**

If yes, please explain?_____

_____

_____

24. How often do you have your teeth examined?_____

Cleaned?_____ X-rayed?_____

25. Have you ever experienced any discomfort from your teeth or gums lately?.....**YES** **NO**

If yes, where?_____

26. Do you breathe through your mouth?.....**YES** **NO**

27. Do you brush your teeth at least twice a day?.....**YES** **NO**

28. Does food generally wedge between certain teeth?.....**YES** **NO**

29. Are you troubled with bad breath?.....**YES** **NO**

30. Has the fear of discomfort kept you from regular dental visits?.....**YES** **NO**

31. Do your gums bleed easily, feel tender or irritated?.....**YES** **NO**

32. Do you use dental floss daily?.....**YES** **NO**

33. Are your teeth sensitive to hot, cold or sweets?.....**YES** **NO**

34. Do you frequently snack between meals on sweets, on starches, or chew gum?.....**YES** **NO**

35. Are you self-conscious about the appearance of your teeth?.....**YES** **NO**

36. Would you like to retain your natural teeth as long as possible?.....**YES** **NO**

37. Are you aware of grinding or clenching your teeth?.....**YES** **NO**

38. Have you lost any teeth other than your wisdom teeth?.....**YES** **NO**

39. Have you noticed any loose, shifted or slanted teeth?.....**YES** **NO**

40. Have you had the nerves of any teeth removed?.....**YES** **NO**

CONSENT:

The undersigned hereby authorizes Conyers Denture and Implant Center (CDIC) to take X-rays, diagnostic casts, photographs, or any other diagnostic aids deemed appropriate by CDIC to perform any and all forms of dental treatments, medication and therapy, that may be indicated and further authorize and consent that CDIC choose and employ such assistance as deemed appropriate. I also understand that the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, and is due and payable at the time services are rendered unless financial arrangements have been made. I also give my permission to contact other health care professionals to discuss my periodontal information.

I understand that according to state and federal law, my health information is private and confidential. I understand that CDIC will only disclose health information to my physician or other healthcare providers providing treatment for me.

I understand that CDIC may disclose my health information to a family member, friend or other person to the extent necessary to help with my healthcare or payment of my healthcare, but only if I agree that CDIC may do so. If required to do so by law, I understand that CDIC may disclose my health information.

Patient:_____ **Date:**_____

Parent or Responsible Party:_____ **Date:**_____

Person to call in
Case of an emergency:_____

Name **Relationship**

Address:_____

(Street/City/State/Zip Code)

Telephone No:_____