Dental Partners of Southwest Georgia – EXSISTING PATIENT UPDATE

Name_____DOB_____ SS#_____

Address (change if applicable)

Street#_____City_____State_____Zip_____

Home # _____ Work #_____ Mobile# _____

E-mail Address_____

Employer_____ Work _____ EXT_____

Dental Insurance: ☐ SAME ☐ NEW **If new:** _____

Your current Medical History Personal Physician Name_____ Phone #_____

Are you currently under the care of a Physician? Yes _____ No _____ Explain_____

Recent Hospitalization? _____Do you smoke or use tobacco products? Yes ____ No ____

Have you had any Metal rods, Pins or Implants? Yes _____ No _____ Do you snore? Yes ____ No ____

Is snoring a problem for you and your relationship? Yes _____ No ____

Are you taking any Prescriptions or Over-the-counter Drugs? Yes _____ No _____

Please List each one_____

(Continued)_____ **_____**

Are you allergic to any Drugs/Materials? _____

In case of Emergency Call Name _____ Phone #_____

Have you ever had any of the following Conditions?

Y N Abnormal Bleeding
Y N Aids
Y N Alcohol/Drug abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Recent Weight Loss
Y N Epilepsy
Y N Fainting spells
Y N Frequent headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart attack/Surgery
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis/Jaundice
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV
Y N Kidney Problems
Y N Liver disease
Y N Low Blood pressure
Y N Other_____
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Sexually transmitted Disease
Y N Heart Disease
Y N Are you pregnant

Signature X _____ Date _____