Conyers Dental Associates, LLC
1455 Old McDonough Rd Suite B
Conyers, GA 30094
Ph # : 770-483-6655

Patient Personal Information

Title ____ Nickname ____ Birth Date ____ Age ____
Last, First ____ ____ ____ Marital Status ____ Sex ____
Address ____ Home # ____ Work # ____
____ Cell # ____ Drive Lic ____
City, State, Zip ____ Emergency Contact ____ Emergency Phone # ____
Email ____ Student ____ SSN ____
Health Care Guardian Name ____ School Name ____
Health Care Guardian Phone # ____ Referral Type ____

Person responsible/guarantor for paying bills

Title ____ Nickname ____ Birth Date ____ Age ____
Last, First ____ Marital Status ____ Sex ____
Address ____ Home # ____ Work # ____
____ Cell # ____ Drive Lic ____
City, State, Zip ____ SSN ____
Email ____

Do you have Primary Dental Insurance? __ Yes __ No

Group No/Name ____
Insurance Name ____
Phone # ____
Employer Name ____
Subscriber Last, First ____
Subscriber Address ____
City, State, Zip ____
Relationship to Patient ____ Birth Date ____
Subscriber ID ____

Do you have Secondary Dental Insurance? __ Yes __ No

Group No/Name ____
Insurance Name ____
Phone # ____
Employer Name ____
Subscriber Last, First ____
Subscriber Address ____
City, State, Zip ____
Relationship to Patient ____ Birth Date ____
Subscriber ID ____

Patient Medical Information

Allergic To

☐ Y ☐ N Known Allergies
☐ Y ☐ N Aspirin
☐ Y ☐ N Barbiturates / Sleeping Pills
☐ Y ☐ N Codeine
☐ Y ☐ N Erythromycin
☐ Y ☐ N Iodine
☐ Y ☐ N Latex Rubber
☐ Y ☐ N Local Anesthetics
☐ Y ☐ N Metals
☐ Y ☐ N Epinephrine
☐ Y ☐ N Penicillin
☐ Y ☐ N Prior Hepatitis
☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Other Narcotics

Check, if applicable

☐ Y ☐ N Ankles Swell
☐ Y ☐ N Anorexia
☐ Y ☐ N Arteriosclerosis
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Atrial Fibrillation
☐ Y ☐ N Autoimmune Disease
☐ Y ☐ N Bladder Trouble
☐ Y ☐ N Blood Clotting Problems
☐ Y ☐ N Blood Thinners (Coumadin/Warfar
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Bulimia
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer / Tumor or Growth
☐ Y ☐ N Cardiac Pacemaker
☐ Y ☐ N Cardiovascular Disease
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters
☐ Y ☐ N Headaches / Migraines
☐ Y ☐ N Frequently Dry Mouth / Sjogren
☐ Y ☐ N Gag Reflex
☐ Y ☐ N Gall Bladder Trouble
☐ Y ☐ N Hay Fever
☐ Y ☐ N Heart Attack
☐ Y ☐ N Heart Disease
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Hepatitis
☐ Y ☐ N Herpes
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N High Cholesterol
☐ Y ☐ N Hives
☐ Y ☐ N Jaundice
☐ Y ☐ N Pacemaker
☐ Y ☐ N Persistent Diarrhea
☐ Y ☐ N Premedicate
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Rheumatic Heart Disease
☐ Y ☐ N Rheumatoid Arthritis
☐ Y ☐ N Seizures
☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Shortness of Breath
☐ Y ☐ N Skin Rash
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Stomach Ulcers
☐ Y ☐ N Stroke
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Tuberculosis

☐ Y ☐ N Change Since Last Recorded
☐ Y ☐ N Known Concerns or Issues
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Acid Reflux
☐ Y ☐ N ADD / ADHD
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Alzheimers/Dementia
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Chest Pain Upon Exertion
☐ Y ☐ N Color Blindness
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Kidney
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Unusual Weight Loss
☐ Y ☐ N Urinate Frequently

Other

☐ Y ☐ N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? ☐

Are your teeth sensitive to hot, cold or sweets ? ☐

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? ☐

Have you ever had burning of the tongue or cracking of the corners of your mouth ? ☐

Do you chew/smoke tobacco in any form ? ☐

Have you had any head, neck or jaw injuries ? ☐

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? ☐

Do you clench or grind your teeth ? ☐

Have you ever had orthodontic treatment ? ☐

If Yes, date of placement _____

Do you wear dentures or partials ? ☐

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? ☐

Are you having any specific problems with your teeth, gums, or mouth at this time ? ☐

Are you happy with your smile ? ☐

Do you have problems with teeth/fillings breaking ? ☐

Do you regularly use dental floss ? ☐

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? ☐

Do you have difficulty in opening your mouth widely ?	☐
Do you have an unpleasant taste or odor in your teeth/mouth ?	☐
Does food catch between your teeth ?	☐
Do you want to learn to control your dental disease and retain your teeth ?	☐

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Patient Notes:

Add allergies, diseases, or problems not listed. _____

Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ?	☐
If Yes, what is the condition being treated ?	_____
Have you had any serious illness, operation or been hospitalized within the past 5 years ?	☐
If Yes, what illness or problem ?	_____
Are you currently taking any medication ?	☐
If Yes, what ?	_____
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	☐
Have you ever taken the diet control drug Fen-Phen ?	☐
Do you use alcoholic beverages ?	☐
Do you smoke ?	☐

Women Only

Are you pregnant?	☐
If Yes, what is your due date ?	_____
Are you currently nursing ?	☐
Do you have menstrual period problems ?	☐
Are you on hormone replacement therapy ?	☐
Are you on birth control pills / fertility drugs ?	☐

Medical Insurance - Optional

Medical Insurance Carrier _____

Address	
City / State / Zip	
Medical Insurance Carrier Phone	
Medical Insurance Carrier Employer Name	
Medical Insurance Carrier Subscriber Name	
Medical Insurance Carrier Subscriber ID #	
Medical Insurance Carrier Subscriber Birthdate	
Additional Comments	
Please add any additional comments.	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date