



Vinings Center for Dentistry

Welcome! How did you learn of our practice? _____ **Thank you for choosing us.**

Full name: _____ Spouse name: _____

Address: _____ Address: _____

City/State: _____ Zip: _____ City/State: _____ Zip: _____

☎ (Hm): _____ ☎ (Hm): _____

☎ (Wk): _____ Ext. _____ ☎ (Wk) _____ Ext. _____

☎ (Cell) _____ ☎ (Cell) _____

E-Mail Address: _____ E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Date of Birth: _____ Age: _____ Sex: _____

Social Security No.: _____ Social Security No.: _____

Occupation: _____ Marital Status: M S D Occupation: _____

Employer: _____ Employer: _____

Employer address: _____ Employer address: _____

Do you have dental insurance? Yes No Does your spouse have dental insurance? Yes No

Insurance company name: _____ Insurance company name: _____

If dual insurance coverage, your insurance is Primary Secondary

Payment method you prefer: Cash or Check Visa / MasterCard / AMEX * See payment policy

MEDICAL AND DENTAL HISTORY

Do you now have or in the past had a history of any of the following: (Answer all questions)

	Yes	No		Yes	No		Yes	No
Heart problems or disease			Bleeding Disorder			Allergic to Penicillin		
High blood pressure			Mitral valve prolapse			Allergic to aspirin		
HIV positive or AIDS			Heart murmur			Allergic to novocaine		
Asthma			Diabetes			Allergic to sulfa drugs		
TB or Tuberculosis			Hepatitis			Allergic to Codeine		
Kidney disease			Immune deficiency			Food / Environmental Allergies?		
Stomach or GI disorder			Respiratory/lung disease			LATEX/ Rubber allergy		
Scarlet Fever			Blood disease			Are you taking medicines now?		
Thyroid Disorder			Cancer			Eating disorder		
Sinusitis, Hay fever			Glaucoma			Liver disease		
Chronic cough			Herpes			Taking birth control pills		
Shortness of breath			Rhematic Fever			Nervous/ anxiety disorder		
Epilepsy			Anemia			Use of Prozac/ antidepressants		
Are you Pregnant?			Sickle cell disease or trait			Steroid treatments		

Are you allergic to or ever had an unfavorable reaction to any drug(s)? Yes No What drug? _____

List any medicines you are now taking: 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____ 7) _____

Name of Physician: _____ Telephone: _____

Dental Questionnaire / History

	Yes	No		Yes	No		Yes	No
I like the way my teeth look			Bad teeth run in my family			I floss my teeth daily		
I have had braces before			My parent(s) had/have dentures			My "bite" feels "off" or my jaw pops or grinds		
I have kept up with good Dental care			I want straight, white, teeth			I am embarrassed by my teeth		
I grind my teeth			I always seem to get cavities			My teeth work or chew well		
My gums bleed sometimes			My teeth are loose			I have had toothaches		
Nicer teeth would give me more confidence			I am aware of breath odor			I tend to go to the dentist only when I have an emergency		

List 3 things that are important to you in a dentist or dental office/visit.	List 3 wishes that you would like to achieve about your teeth.

Is there any additional information we should know before your treatment is begun? _____

Date

Signature

RESPONSIBILITY OF CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself _____ (name). I give my consent, as an adult, to any advisable and necessary dental procedures, medications, or anesthetics administered by Dr. Lumpkin, attending dentist or by supervised staff of the Vinings Center for Dentistry, PC for diagnostic purposes and dental treatment. I have answered all health history questions and disclosed any information that would be needed in my treatment truthfully and thoroughly to the best of my ability and knowledge.

Date

Signature

BROKEN APPOINTMENT FEE:

There is a \$45.00 fee for all appointments missed or cancelled without 24 hour notice.

Initials:

(DOCTOR'S NOTES)