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**)

Heart Problems or Disease	Yes	No	Blood Disease	Yes	No	Head Injury	Yes	No
High Blood Pressure			Sickle Cell Disease or Trait			Joint Replacement		
Are you on a Blood Thinner?			Asthma / Short of Breath			Allergic to Aspirin		
Mitral Valve Prolapse			TB or Tuberculosis			Allergic to Novocaine		
Heart Murmur			Respiratory / Lung Disease			Allergic to Sulfa Drugs		
Pacemaker			Kidney Disease			Allergic to Codeine		
Stroke			Diabetes			Allergic to Penicillin		
Glaucoma			Liver Disease			Food / Environmental Allergies?		
Stomach or GI Disorder			Hepatitis			LATEX / Rubber allergy		
Sinusitis, Hay Fever			Cancer			Eating Disorder		
Thyroid Disorder			Radiation / Chemotherapy			Steroid treatments		
Epilepsy			Tumors			Use of Prozac / Antidepressants		
Scarlet or Rheumatic Fever			Immune deficiency			Nervous / Anxiety Disorder		
Bleeding Disorder			HIV positive or AIDS			Taking Birth Control Pills?		
Anemia			Herpes			Are you Pregnant?		

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 Physcian:_____Telephone:_____

Do you use any type of tobacco products? Yes or No

If yes, please list the type of tobacco product and the frequency of use _____

_____

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: _____