Dentistry at Hamilton Mill
3625 Braselton Hwy
Suite #102
Dacula GA 30019

www.KinseySmiles.com
(678)714-0525
office@kinseysmiles.com

Medical History

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Allergies
- ☐ Allergy Codeine
- ☐ Allergy Latex
- ☐ Allergy Penicillin
- ☐ Allergy Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Trouble
- ☐ Blood Disease
- ☐ Cancer
- ☐ Ceclor
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/dizziness
- ☐ Glaucoma
- ☐ Handicapped
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ PRE-MED
- ☐ Radiation Tx
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Subject to frequent headaches
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list below

* ◯ Yes ◯ No

Medications:

Name and phone number of preferred pharmacy:

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

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Comprehensive Dental Care

Our treatment philosophy is one that focuses on comprehensive and complete dental treatment in order to restore and maintain our patients in a state of health. In order to perform a thorough evaluation of your oral health, it is essential that we have current x-rays of high diagnostic quality. Without x-rays, we are unable to accurately assess the health of your teeth, gums, bone, and surrounding structures. Without an accurate diagnosis of your teeth and surrounding areas, such things as tooth decay, periodontal diseases, abscesses, cysts, and even cancerous tumors can go undiagnosed which can cause extensive irreversible damage that may not be discovered until there are symptoms.

Scheduled Appointments

When you have an appointment scheduled in our office, our entire staff will do everything we can to make sure we have everything ready for you so that we can get you in and out on a timely basis. You, as the patient, are responsible for keeping your scheduled appointment. As a courtesy, we will send electronic reminders in advance to confirm your appointment. It is your responsibility to inform us of any changes with email or contact numbers. Please understand that we expect you for your appointment whether or not we are able to reach you. If, for any reason, you cannot keep an appointment, please call our office at least two working days in advance during regular business hours, as we are not responsible for messages left on an answering machine. There will be a charge for a missed appointment or late cancellation (48 hours).

* ☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

Name of person completing this form

*

Relationship to patient

* ◯ Self ◯ Parent ◯ Spouse ◯ Guardian ◯ Other

Response Date: