Dental Care Associates of Waycross

1601 B Alice Street • Waycross, GA 31501 • (912) 285-5967

PATIENT NUMBER

DENTAL HISTORY

Patient's Name _____
Last First Initial Nickname Date of Birth

Purpose of initial visit _____
Are you aware of a problem? ..... YES NO DON'T KNOW
How long since your last dental visit? _____
What was done at that time? _____
Previous dentist's name _____
Address & phone _____
When was the last time your teeth were cleaned? _____
Have you made regular visits? ..... YES NO DON'T KNOW
How often _____
Were dental x-rays taken? ..... YES NO DON'T KNOW
Have you lost any teeth or have any teeth been removed? ..... YES NO DON'T KNOW
Why? _____ Have they been replaced? ..... YES NO DON'T KNOW
How have they been replaced? Fixed Bridge _____ Age _____ Removable Bridge _____ Age _____
Denture _____ Age _____ Implant _____ Age _____
Are you unhappy with the replacement? ..... YES NO DON'T KNOW
If yes, explain _____
Would you like to know about permanent replacements? ..... YES NO DON'T KNOW
Have you ever had any problems or complications with previous dental treatment? ..... YES NO DON'T KNOW
If yes, explain _____
Do you clench or grind your teeth? ..... YES NO DON'T KNOW
Does your jaw click or pop? ..... YES NO DON'T KNOW
Have you experienced any pain or soreness in the muscles in your face or around your ear? ..... YES NO DON'T KNOW
Do you have frequent headaches, neck aches or shoulder aches? ..... YES NO DON'T KNOW
Does food get caught in your teeth? ..... YES NO DON'T KNOW
Are any of your teeth sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Pressure
Do your gums bleed or hurt? ..... YES NO DON'T KNOW
When? _____
Do you experience dry mouth? ..... YES NO DON'T KNOW
How often do you brush your teeth? _____ When? _____
Do you use dental floss? ..... YES NO DON'T KNOW
How often? _____
Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO DON'T KNOW
Are you unhappy with the appearance of your teeth? ..... YES NO DON'T KNOW
How do you feel about your teeth in general? ..... YES NO DON'T KNOW
Do you feel your breath is offensive at times? ..... YES NO DON'T KNOW
Have you ever had gum treatment or surgery? ..... YES NO DON'T KNOW
What? _____
Where? _____ When? _____
Have you had any orthodontic work? ..... YES NO DON'T KNOW
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ..... YES NO DON'T KNOW
Do you have any questions or concerns? ..... YES NO DON'T KNOW

COMMENTS

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____

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PATIENT NUMBER

MEDICAL HISTORY

Patient's Name _____
Last First Initial Nickname Date of Birth

Physician's Name _____
Address & Phone _____
Are you under a physician's care? ..... YES NO DON'T KNOW
Since when? _____ Why _____
When was your last complete physical exam? _____
Are you taking any medication or substances? ..... YES NO DON'T KNOW
(If yes, please list medications in comments section or on the back of this form.)
Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ..... YES NO DON'T KNOW
Are you allergic to any medications or substances? (please list) ..... YES NO DON'T KNOW
Do you have any other allergies or hives? ..... YES NO DON'T KNOW
Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO DON'T KNOW
Are you sensitive to any metals or latex? ..... YES NO DON'T KNOW
Are you pregnant or suspect you may be? ..... YES NO DON'T KNOW
Do you use any birth control medications? ..... YES NO DON'T KNOW
Have you ever been treated for or been told you might have heart disease? ..... YES NO DON'T KNOW
Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ..... YES NO DON'T KNOW
Have you ever had rheumatic fever? ..... YES NO DON'T KNOW
Are you aware of any heart murmurs? ..... YES NO DON'T KNOW
Do you have high or low blood pressure? (please circle) ..... YES NO DON'T KNOW
Have you ever had a serious illness or major surgery? ..... YES NO DON'T KNOW
If so, explain _____
Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO DON'T KNOW
Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ..... YES NO DON'T KNOW
Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO DON'T KNOW
Do you have any artificial joints/prosthesis? ..... YES NO DON'T KNOW
Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO DON'T KNOW
Have you ever bled excessively after being cut or injured? ..... YES NO DON'T KNOW
Do you have any stomach problems? ..... YES NO DON'T KNOW
Do you have any kidney problems? ..... YES NO DON'T KNOW
Do you have any liver problems? ..... YES NO DON'T KNOW
Are you diabetic? ..... YES NO DON'T KNOW
Do you have fainting or dizzy spells? ..... YES NO DON'T KNOW
Do you have asthma? ..... YES NO DON'T KNOW
Do you have epilepsy or seizure disorders? ..... YES NO DON'T KNOW
Do you or have you had venereal or any sexually transmitted disease? ..... YES NO DON'T KNOW
Have you tested HIV positive? ..... YES NO DON'T KNOW
Do you have AIDS? ..... YES NO DON'T KNOW
Have you had or do you test positive for hepatitis? ..... YES NO DON'T KNOW
Do you or have you had T.B.? ..... YES NO DON'T KNOW
Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO DON'T KNOW
Do you regularly consume more than one or two alcoholic beverages a day? ..... YES NO DON'T KNOW
Do you habitually use controlled substances? ..... YES NO DON'T KNOW
Have you had psychiatric treatment? ..... YES NO DON'T KNOW
Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... YES NO DON'T KNOW
Do you have any disease condition, or problem not listed? If so, explain ..... YES NO DON'T KNOW
Is there anything else we should know about your health that we have not covered in this form? ..... YES NO DON'T KNOW
Would you like to speak to the Doctor privately about any problem? ..... YES NO DON'T KNOW

COMMENTS

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____

DENTAL CARE ASSOCIATES
OF WAYCROSS *Our focus is your smile*

Medication List

If you are taking any medications, please complete this form.

My Name is _____

My Health Care Provider's Name is _____

My Health Care Provider's Phone Number is _____

I am currently taking the following medications:

Medication	When I take it	Dose	Other Instructions

William Keith Crummey, DMD • Ty Bennett, DMD
1601 B Alice Street, Waycross, GA 31501 • Phone (912) 285-5967 Fax (912) 285.0762