



BRAD DIXON D.M.D., F.A.G.D.

Personal Information

Date:
Name:
Patient Address:
City: State: Zip:
E-Mail:
Phone (Home):
Phone (Work): Ext.:
Phone (Cell):
Where do you prefer to receive calls? () Home () Work () Cell

SPOUSE / RESPONSIBLE PARTY INFORMATION

The following is for:
() the patient's spouse () the person responsible for payment
Name:
() Male () Female () Married () Single () Child
() Other:
Social Security #:
Birth Date:
Driver's License#:
Phone (Home):
Phone (Work): Ext.:
Best time to call:
Address:
City: State: Zip:

INSURANCE INFORMATION

Name of Insured:
Is Insured a Patient? () Yes () No
Insured's Birth Date:
ID #: Group #:
Insured's Address:
City: State: Zip:
Insured's Employer Name:
Address:
City: State: Zip:
Patient's Relationship to Insured:
Insurance Plan Name and Telephone:

I authorize Dr. Dixon or his employees to release any information concerning my dental treatment or my child's to third party payers and/or health practitioners.
Signature of patient or parent of minor

PHOTO RELEASE

I, _____ hereby authorize Dr. Brad Dixon to take photographs, slides and/or videos of my face, jaws and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals) further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: Date:
Reviewed: Date: Dr.:

Medical History

Date:
Name:
We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. We hate filling out forms as much as you do, but this information is very important. Thank you in advance for your cooperation.
What is the estimate of your general health? () Poor () Fair () Good

MEDICATIONS

What medications are you taking, including "over the counter", i.e. Aspirin, vitamins, etc.?

ALLERGIES / ADVERSE REACTION

Aspirin, ibuprofen, acetaminophen () Yes () No
Penicillin or other antibiotic () Yes () No
Sulfa () Yes () No
Barbiturates, sedatives or sleeping pills () Yes () No
Codeine or other narcotics () Yes () No
Latex () Yes () No Acrylic () Yes () No
Metals () Yes () No Other: _____

HEART/BLOOD PRESSURE PROBLEMS

Your normal blood pressure _____ / _____
Heart murmur () Yes () No
Do you take antibiotics for dental appointments? () Yes () No
Stroke () Yes () No
Heart attack / failure () Yes () No
Pace maker () Yes () No
Rheumatic fever () Yes () No
Angina () Yes () No
Damaged or artificial heart valve () Yes () No
Do you have chest pain upon exertion? () Yes () No

HEART/BLOOD PRESSURE PROBLEMS Cont.

Are you ever short of breath after mild exercise or when lying down?
() Yes () No

Do you use more than 1 pillow to sleep? () Yes () No

Do your ankles swell? () Yes () No

Periodontal Disease and Dental Infections may increase the risk of Stroke and Coronary Heart Disease.

BLEEDING

Do you bleed easily? Aspirin can cause this. () Yes () No

Are you on Coumadin or other blood thinners? () Yes () No

Do you have Hepatitis? A () B () C () D () Jaundice ()

Blood Disease () Yes () No

DIABETES

Do you have Diabetes? () Yes () No ()

Type 1 () Type 2 Latest HbA1c Score _____ %

Do you have to go to the bathroom often? () Yes () No

Recent studies have shown a link between Diabetes and Periodontal Disease. It is important to your health that they both are under control. The warning signs of Diabetes are frequent trips to the bathroom, thirsty all the time, and always feeling hungry.

BREATHING / LUNGS / TUBERCULOSIS / EMPHYSEMA

() Sinus problems () Seasonal Allergies () Bronchitis () Asthma

() Snoring *Ask Your Spouse!*

() Is it hard to breathe normally through your nose?

Were your tonsils removed? () Yes () No

How many times do you wake up at night? _____

Do you need help sleeping? () Yes () No

What do you do? _____

Do you wake up tired? () Yes () No

Do you use a CPAP for sleeping? () Yes () No

Lung disease () Yes () No

PREGNANCY

Are you pregnant or trying? () Yes () No

Are you nursing? () Yes () No

Are you taking birth control pills? () Yes () No

Antibiotics can interfere with birth control pills by causing them not to work. Periodontal infections can increase the risk for low birth weights in newborns. This is very dangerous!

CANCER

Do you or have you ever had cancer, tumor or abnormal growth?

() Yes () No

When? _____

What kind? _____

How are you being or were you treated? _____

GENERAL QUESTIONS

Do you smoke? () Yes () No How many packs/day?

Do you chew tobacco? () Yes () No How much? _____

Are you nervous? "Not just because you are in a dental office"

() Yes () No

Do you have a Mental Health Disorder? () Yes () No

What is it? _____

Do you get dizzy often or if you stand up too fast? () Yes () No

Do you feel bad if you skip lunch? () Yes () No

Have you had any serious illness, operation or been hospitalized in the past 5 years? () Yes () No

If so, what was the condition treated? _____

Viral Infection () Yes () No

Fever Blisters () Yes () No

Cold Sores () Yes () No

Ulcers (canker sore) () Yes () No

GENERAL QUESTIONS Cont.

Any lumps or swelling in the mouth? () Yes ()

No Have you ever been told to pre-medicate for dental treatment?

() Yes () No

Thyroid / Parathyroid disease () Yes () No

Glaucoma () Yes () No

Are you considered a touchy person? () Yes () No

Are you often unhappy or depressed? () Yes () No

Are you easily upset or irritated? () Yes () No

Kidney Disease () Yes () No

MALE

Prostate disorders () Yes () No

STOMACH / DIGESTION

Stomach / duodenal (peptic) ulcer () Yes ()

No Digestive disorders () Yes () No

NERVES / MUSCLES / BONES

Do you have back problems () Yes () No

Can you lie in a dental chair comfortably () Yes () No

Do you have a Neuromuscular Disorder? () Yes () No

What is it? _____

Arthritis / painful joints () Yes () No

Artificial / prosthetic joints () Yes () No

If yes, when placed? _____

IMMUNE SYSTEM

() Lupus () Organ Transplant () HIV () AIDS () ARC

PHYSICIANS / PHYSICAL THERAPIST / CHIROPRACTORS

Are you under the care of a physician? () Yes () No

Please list everyone who is treating you at this time.

Name: _____ Phone: _____

Treatment: _____

Name: _____ Phone: _____

Treatment: _____

Name: _____ Phone: _____

Treatment: _____

Name: _____ Phone: _____

Treatment: _____

Anything else you feel we need to know about the systems of your body? _____

The above information is accurate and complete to the best of my knowledge. If I ever have any change in my medical history or the medications I take, I will inform the doctor at the next appointment without fail. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

Whom may we thank for referring you to our practice?

() Another patient, friend () Another Doctor () Dental Office

() School () Work () Other: _____

Name of person or office referring you to our practice _____

Signature: _____

Date: _____

Reviewed: Date: _____

Dr. _____

Dental Concerns

Date: _____

Name: _____

Other than trauma – people lose their teeth because of decay (cavities); periodontal (gum) disease or problems with the bite.

Do you think you have decay, gum disease or bite problems?

() Yes () No

Check all that apply:

- | | |
|--|----------------------------|
| () Headaches <input type="checkbox"/> | () Facial Pain |
| () TMJ Pain <input type="checkbox"/> | () Tender Sensitive Teeth |
| () TMJ Noise <input type="checkbox"/> | () Difficulty Chewing |
| () Limited Opening | () Neck Pain |
| () Ear Congestion | () Postural Problems |
| () Dizziness <input type="checkbox"/> | () Tingling In Fingers |
| () Ringing In Ears <input type="checkbox"/> | () Hot & Cold Sensitivity |
| () Difficulty Swallowing <input type="checkbox"/> | () Nervousness |
| () Loose Teeth | () Insomnia |
| () Clenching/Bruxing <input type="checkbox"/> | () Trigeminal Neuralgia |
| () Bells Palsy <input type="checkbox"/> | () Back Pain |
| () Dry Mouth | |

Do you sweat or tremble a lot during examination? () Yes () No

Do strange people or places make you afraid? () Yes () No

What are your feelings about your:

FRONT TEETH

Are you happy with their color? () Yes () No

Would you like whiter teeth? () Yes () No

Are you happy with their length? () Yes () No

Are they crowded or crooked? () Yes () No

Are braces an option? () Yes () No

Are you happy with their overall appearance? () Yes () No

Anything About Them You Would Change? _____

BACK TEETH

Can you chew comfortably? () Yes () No

Are they sensitive to hot or cold foods? () Yes () No

Do they trap food when you eat? () Yes () No

Anything about them you would change? _____

GUMS

How often do you have your teeth cleaned?

() 3 mo () 4 mo () 6 mo () 1 year or longer

Have you had previous gum treatment? () Yes () No

When: _____

Do they ever bleed? () Yes () No

Are you seeing a Periodontist? () Yes () No

Who: _____

Do you floss? () Yes () No

How often: _____

Are they sensitive? () Yes () No

Do you have bad breath or bad taste? () Yes () No

Do you use products such as mints, mouth rinse or chewing gum

to help maintain fresh breath? () Yes () No

Anything about them you would change? _____

BITE / MISSING TEETH

Are your teeth worn or chipped? () Yes () No

Do any teeth hurt to chew or are sore? () Yes () No

Does it hurt to open wide or take a bite out of something? () Yes () No

Is your bite comfortable when chewing? () Yes () No

Do you ever have any clicking, popping or discomfort in your jaw joint? () Yes () No

Do you have any missing teeth? () Yes () No

Are you wearing a denture or partial denture? () Yes () No

Is your denture or partial comfortable? () Yes () No

Are you satisfied with your chewing ability? () Yes () No

Anything about them you would change? _____

What did you not like about your last dental appointment?

() Was the treatment uncomfortable?

() Was the staff unfriendly?

() Were the fees not explained before your appointments?

() Anything we have not thought of? _____

What is the first thing you would like for us to help you with?

List in order of importance: _____

Signature: _____

Date: _____

Reviewed: Date: _____

Dr. _____

Brad Dixon, DMD

690 Lanier Park Drive / Gainesville, GA 30501

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

(Please Print Name)

I, _____
have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- () Individual refused to sign
- () Communications barriers prohibited obtaining the acknowledgement
- () An emergency situation prevented us from obtaining acknowledgement
- () Other (Please Specify) _____