

# NORCROSS DENTAL CENTER

## Medical History & Patient Information Form

5430 Jimmy Carter Blvd, Suite #125, Norcross, GA 30093 | (770) 441-7900

### 1. PATIENT INFORMATION

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship / Phone: \_\_\_\_\_

### 2. MEDICAL HISTORY – Please check all that apply

☐ High Blood Pressure

☐ Heart Disease / Heart Attack

☐ Diabetes

☐ Asthma / Breathing Problems

☐ Stroke

☐ Cancer

☐ Kidney Disease

☐ Liver Disease / Hepatitis

☐ HIV / AIDS

☐ Epilepsy / Seizures

☐ Thyroid Problems

☐ Arthritis

☐ Bleeding Problems

☐ Artificial Joints / Implants

☐ Pacemaker

☐ Psychiatric Care / Anxiety

☐ Sleep Apnea

☐ Other: \_\_\_\_\_

Please list any other medical conditions: \_\_\_\_\_

### 3. MEDICATIONS & ALLERGIES

Current medications (include dosage if known):

\_\_\_\_\_  
\_\_\_\_\_

Allergies (medications, latex, metals, foods, etc.):

\_\_\_\_\_  
\_\_\_\_\_

### 4. DENTAL HISTORY

☐ Sensitive teeth

☐ Bleeding gums

☐ Loose teeth

☐ Jaw pain / TMJ

☐ Clicking / popping jaw

☐ Grind / clench teeth

☐ Previous root canals

☐ Previous extractions

☐ Dentures / Partials

☐ Orthodontics (braces)

☐ Difficulty chewing

☐ Bad breath

Reason for today's visit: \_\_\_\_\_

Last dental visit / cleaning: \_\_\_\_\_ Last X-rays: \_\_\_\_\_

### 5. CONSENT & ACKNOWLEDGEMENT

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that providing incorrect information may affect my treatment. I consent to examination and treatment as recommended by the dentist. I authorize the release of necessary medical/dental information to insurance companies or other providers involved in my care.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

