GOWASACK FAMILY DENTISTRY

Brian J. Gowasack, DDS
1498 Klondike Rd, Ste 201 · Conyers, GA 30094
Phone 770.922.7900

PATIENT MEDICAL HISTORY

PATIENT NAME: ____________________

Physician: ____________________

Office Phone: ____________________

Date of Last Exam: ____________________

Are you under medical treatment now?	☐ YES	☐ NO
Have you ever been hospitalized for any surgical operation or serious illness?	☐ YES	☐ NO
Are you taking any medications?	☐ YES	☐ NO

Including non-prescription, please list: ____________________

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Have you ever taken Fen-Phen/Redux?	☐ YES	☐ NO
Do you use tobacco?	☐ YES	☐ NO
Do you use alcohol, cocaine or other drugs?	☐ YES	☐ NO

ARE YOU ALLERGIC TO, OR HAVE YOU EVER HAD A REACTION TO:

Local Anesthetics like Novocaine	☐ YES	☐ NO
Penicillin or other antibiotics	☐ YES	☐ NO
Sulfa drugs	☐ YES	☐ NO
Barbiturates, sedatives or sleeping pills	☐ YES	☐ NO
Aspirin	☐ YES	☐ NO
Iodine	☐ YES	☐ NO
Any metals (nickel, mercury, etc.)	☐ YES	☐ NO
Latex or rubber	☐ YES	☐ NO
Other	☐ YES	☐ NO

Please list: ____________________

WOMEN ONLY:

Are you pregnant or think you may be pregnant?	☐ YES	☐ NO
Are you nursing?	☐ YES	☐ NO
Are you taking birth control pills?	☐ YES	☐ NO

DO YOU HAVE, OR HAVE YOU EVER HAD:

☐ AIDS/HIV Positive	☐ Diabetes	☐ Heart Trouble/Disease	☐ Radiation Treatments	☐ OTHER
☐ Allergies	☐ Easily Winded	☐ Hemophilia	☐ Recent Weight Loss	*Please explain:* ________
☐ Anemia	☐ Emphysema	☐ Hepatitis/Jaundice	☐ Respiratory Problems	________
☐ Angina	☐ Epilepsy or Seizures	☐ High/Low Blood Pressure	☐ Rheumatic Fever	________
☐ Arthritis/Rheumatism	☐ Fainting Spells/Dizziness	☐ Joint Replacement/Implant	☐ Sickle Cell Disease	________
☐ Artificial Valves	☐ Frequently Tired	☐ Kidney Problems	☐ Stomach Trouble/Ulcer	________
☐ Asthma	☐ Glaucoma	☐ Leukemia	☐ Stroke	*Comments:* ________
☐ Cancer	☐ Hay Fever/Allergies	☐ Liver Disease	☐ Swelling of Limbs	________
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Lupus	☐ Thyroid Disease	________
☐ Chest Pains	☐ Heart Murmur	☐ Persistent Cough	☐ Tuberculosis	________
☐ Colitis	☐ Heart Pacemaker	☐ Psychiatric Problems	☐ Venereal Disease	________

PATIENT DENTAL HISTORY

Would you like fresher breath?	☐ YES	☐ NO
Would you like whiter teeth?	☐ YES	☐ NO
Do your gums ever bleed?	☐ YES	☐ NO
Are your teeth sensitive to hot/cold liquids/foods?	☐ YES	☐ NO
Are your teeth sensitive to sweet/sour liquids/foods?	☐ YES	☐ NO
Do you feel pain in any of your teeth?	☐ YES	☐ NO
Do you have any sores or lumps in or near your mouth?	☐ YES	☐ NO
Do you have frequent headaches?	☐ YES	☐ NO
Do you clench or grind your teeth?	☐ YES	☐ NO
Do you bite your lips or cheeks frequently?	☐ YES	☐ NO
Have you had any head, neck or jaw injuries?	☐ YES	☐ NO
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐ YES	☐ NO
Pain (joint, ear, side of face)	☐ YES	☐ NO
Difficulty opening or closing	☐ YES	☐ NO
Difficulty chewing	☐ YES	☐ NO
Have you ever had any orthodontic work?	☐ YES	☐ NO
Have you ever had any difficult extractions in the past?	☐ YES	☐ NO
Have you ever had prolonged bleeding following an extraction?	☐ YES	☐ NO

AUTHORIZATIONS

PAYMENT IS DUE AT THE TIME OF SERVICE: My method of payment will be: ☐ Cash/Check ☐ Credit Card ☐ Dental Financing ☐ Dental Insurance

1 I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

2 I certify that I am covered by ____________________ insurance company and I assign directly to Gowasack Family Dentistry all insurance benefits, otherwise payable to me. I understand I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

SIGNATURE: ____________________ **DATE:** ____________________

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of Infection Control mandated by OSHA, the CDC, and the ADA.