GETTING TO KNOW YOU

James A. Roos D.M.D., P.C.
672 Concord Road SE Smyrna, GA 30082
Phone: (770) 434-5051 Fax: (770) 434-5228

Name:_____ **Date:**_____

Dental History

Primary Reason for your visit today_____

_____

Approximate date of last dental visit_____ **Hygiene Visit**_____

Are you having pain or discomfort now? ☐Yes ☐No _____

Do you feel nervous about having dental treatment? ☐Yes ☐ No

Are you happy with the appearance of you teeth? ☐Yes ☐ No

If no, please describe_____

Are you interested in bleaching your teeth? ☐ Yes ☐No

Have you noticed or been told that you have any of the following?

Gum disease (gingivitis)	☐Yes	☐No	**Broken teeth or fillings**	☐ Yes	☐No
Gums bleed while brushing/flossing	☐Yes	☐No	**Food collection between teeth**	☐Yes	☐ No
Loose teeth	☐ Yes	☐ No	**Sores, blisters or growths**	☐Yes	☐No
Grind your teeth	☐ Yes	☐ No	**Bad Breath**	☐ Yes	☐ No
Clicking or popping jaw	☐Yes	☐No	**Use of Mouth Rinse**	☐ Yes	☐ No
Jaw pain or soreness	☐Yes	☐No	**Coffee, tea, sodas** (Circle all that apply)	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No		**#_____/day**	
Lip or cheek biting	☐Yes	☐No			

Sensitivity to: ☐ **cold** ☐ **heat** ☐**sweets** ☐ **when biting or chewing/ Area**_____

I hereby authorize Dr. Roos and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Roos to make a thorough diagnosis of (name of patient)_____'s dental needs. Upon diagnosis I also authorize Dr. Roos to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Signature_____**Date**_____

PERSONAL INFORMATION - HEALTH HISTORY

James A. Roos D.M.D., P.C.

www.mysmyrnadentist.com

Name_____ **Birth date**_____

Address_____

Social security No._____ **Preferred Appointment Times/Days**_____

Phone: (home)_____ **(work)**_____ **(cell)**_____

Email_____ **Best number to contact you**_____

Emergency contact name and no._____

Employer Name_____ **Occupation**_____

Whom may we thank for referring you to our office?_____

Spouse or Responsible Party Information (if someone other than yourself)

Name_____ **Employer**_____

Birth date_____ **Social Security No.**_____ **Best Number to contact**_____

Address_____

Health History (please check if you have or had any of the following)

☐ Yes ☐ No	**Are you in good health?**	☐ Yes ☐ No	**Depression/Anxiety Meds:**_____
☐ Yes ☐ No	**Bleeding problems, bruise easily**	☐ Yes ☐ No	**Kidney or bladder disease**
☐ Yes ☐ No	**Headaches, ringing in ears**	☐ Yes ☐ No	**Veneral Disease, herpes**
☐ Yes ☐ No	**Joint pain or stiffness, arthritis**	☐ Yes ☐ No	**HIV positive, AIDS**
☐ Yes ☐ No	**Fainting seizures**	☐ Yes ☐ No	**Latex Allergy**
☐ Yes ☐ No	**Heart disease, murmurs, rheumatic fever, mitral valve prolapse**	☐ Yes ☐ No	**Cold sores/ Fever blisters**
☐ Yes ☐ No	**Premed** _____	☐ Yes ☐ No	**TB, emphysema, or lung disease**
☐ Yes ☐ No	**High blood pressure**	☐ Yes ☐ No	**Diabetes**
☐ Yes ☐ No	**Hepatitis or liver disease**	☐ Yes ☐ No	**Sickle cell disease**
☐ Yes ☐ No	**Acid Reflux**	☐ Yes ☐ No	**Thyroid problem**
☐ Yes ☐ No	**Tumors, cancer**	☐ Yes ☐ No	**Ulcers**
☐ Yes ☐ No	**Radiation treatment/Chemotherapy**	☐ Yes ☐ No	**Tobacco products**
		☐ Yes ☐ No	**Tree nut or peanut allergy**

Women **Yes** **No** **Are you pregnant?** **Yes** **No** **Are you breastfeeding?**

Yes **No** **Are you taking any osteoporosis medication? List**_____

List any allergies_____

List any medications you are currently taking_____

_____

List any surgeries in last 2 years_____