Sugar Hill Corners
Family and Cosmetic Dentistry

5885 Cumming Hwy
Suite 104-105
Sugar Hill. GA 30518

Phone (678) 765-8650

www. Sugarhillcornersdentistry.com

Dental History and Information

Medical History (check all that apply):

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Crohn's/Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV/Aids
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis: ○A ○B ○C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ **Please check this box if you currently take or have ever taken bone replacement medicine.**

Drug Allergies:

Aspirin
Codeine
Dental Anesthetics
Erythromycin
Latex
Metals
Penicillin
Sulfa
Tetracycline
Other ________________
____

Conditions (check all that apply):

Pain/Discomfort
Sensitive Teeth
Bleeding Gums
Bad Taste
Clench or Grind Teeth
Anxiety Regarding Dental Treatments
Excessive Bleeding or Swelling
Have had past Treatment for Gum Disease
Do you?
- Brush Regularly?
- Floss Regularly

Do you smoke or chew tobacco?
Are you happy with your smile?
- Yes
- No (what would you change?)_________
  ____

Females:
- Do you take birth control pills?
- **Are you currently pregnant? (Please let front desk know)**

List any medications you are currently taking:

____

____

Treatment Authorization: I hereby give consent for dental services to be performed that have been agreed upon between the doctor and myself and/or my parent or guardian, including the use and/or prescription of local anesthesia or other medication. I certify that the above is an accurate and thorough statement regarding my medical condition:

Signature: ____ Date: ________________

Let us see your family smile!