ROBERT W. JOHNSON DMD

Dental Partners of Southwest Georgia

Name______________________________DOB________________SS#___________________ Sex **M / F**

Address___________________________________City_______________State________Zip___________

Home #____________________ Cell # _____________________E-Mail___________________________

Employer____ Work #______________________________

Employer Address______________________________ May we contact you at work? Yes_____ No_____

Primary Insurance________________________________ Sec. Insurance ___________________________

Spouse / Parent / Guardian (Circle One)

Name_______________________________DOB___________________SS#________________________

E-mail Address____

Address___________________________________City_________________State________Zip_________

Employer_______________________________ Work #__________________Cell #_________________

In Case of Emergency Name______________________________ Phone # _________________________

How did you find out about our office? Internet______ Phone Book______ Friend/Family______
Other__________________________

Who may we thank for your referral? ____

Reason for Visit____

Please initial the following:

___________ **Consent:** As the undersigned, I hereby authorize Dr. Robert W. Johnson to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a diagnosis of my dental needs. I also authorize Dr. Robert W. Johnson to perform all forms of treatment, medication, and therapy that may be indicated. I also understand that responsibility for payment of Dental Services provided in this office for myself and my family is mine.

___________ **If I am applying for credit, I authorize Dr. Robert W. Johnson's office to check my credit.**

Signature ____ Date__________________________

ROBERT W. JOHNSON DMD

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Your current Medical History

Are you currently under the care of a physician? Yes____ No ____ Explain_________________________

Personal Physician Name___________________________ Phone #______________________

Recent Hospitalization?_____________________ Do you smoke or use tobacco products? Yes____ No____

Have you had any metal rods, pins, or implants? Yes_____ No_____

Are you taking any Prescription or Over-the-counter Drugs? Yes_____ No_____

Please list each one____

____

Are you **allergic** to any Drugs/Materials?____

Your current Dental Health is Good_____ Fair_____ Poor_____ Do your gums bleed? Yes____ No____

Have you ever had Gum Disease? Yes____ No____ Are your teeth sensitive to heat/cold? Yes____ No_____

Date of last Dental Visit_______________________Procedure________________________________

Have you ever had any of the following conditions? (Circle Y or N)

Y / N ABNORMAL BLEEDING	**Y / N** EPILEPSY	**Y / N** MITRAL VALVE PROLAPSE
Y / N AIDS	**Y / N** FAINTING SPELLS	**Y / N** PACEMAKER
Y / N ALCOHOL/DRUG ABUSE	**Y / N** FREQUENT HEADACHES	**Y / N** PSYCHIATRIC PROBLEMS
Y / N ANEMIA	**Y / N** GLAUCOMA	**Y / N** RADIATION TREATMENT
Y / N ARTHRITIS	**Y / N** HAY FEVER	**Y / N** SCARLET FEVER
Y / N ARTIFICIAL BONES / JOINTS	**Y / N** HEART ATTACK/SURGERY	**Y / N** SEIZURES
Y / N ARTIFICIAL VALVES	**Y / N** HEART MURMUR	**Y / N** SHINGLES
Y / N ASTHMA	**Y / N** HEMOPHILLA	**Y / N** SICKLE CELL DISEASE
Y / N BLOOD TRANSFUSION	**Y / N** HEPATITIS/JAUNDICE	**Y / N** SINUS PROBLEMS
Y / N CANCER/CHEMOTHERAPY	**Y / N** HERPES/FEVER BLISTERS	**Y / N** STROKE
Y / N COLITIS	**Y / N** HIGH BLOOD PRESSURE	**Y / N** THYROID PROBLEMS
Y / N CONGENITAL HEART DEFECT	**Y / N** HIV	**Y / N** TUBERCULOSIS (TB)
Y / N DIABETES	**Y / N** KIDNEY PROBLEMS	**Y / N** ULCERS
Y / N DIFFICULTY BREATHING	**Y / N** LIVER DISEASE	**Y / N** EMPHYSEMA
Y / N SEXUALLY TRANSMITTED DISEASE	**Y / N** LOW BLOOD PRESSURE	**Y / N** HEART DISEASE
Y / N RECENT WEIGHT LOSS	**Y / N** ARE YOU PREGNANT	**OTHER**________________________

Signature ____ **Date**________________________________