**John F. Freemon, D.M.D., P.C.**
**209 Creekstone Ridge**
**Woodstock, GA 30188**

**Office: (770) 928-0871 Fax: (678) 619-2048**

## Patient Information

Patient Name: ______________________________ Date: ______________
Last, First MI (Preferred Name)

Gender: M ☐ F ☐ Single ☐ Married ☐ **EMAIL:** ______________________________

Date of Birth: ______________ **Social Security #:** ______________________

**Phone (Home):** ______________________ **(Work)** ______________________ **Ext:** ________

**Appointment Texting OK Y** ☐ **N** ☐ Cell Phone: ______________________

Address: ____________________________________________________________

____________________________________________________________

**Whom can we thank for referring you to our office?** ______________________________

## Dental Insurance Information

**Employer Name:** ______________________ **Insurance Plan On File:** ______________________

**Name of** Insured: ______________________________ **Is insured a patient? Yes No**
Last First

**Insured's Birth Date:** ______________ **ID #:** ______________ **Phone #:** ______________________

## Dental History

**Reason for todays visit?** ______________________ **Former Dentist:** ______________________

**Date of last x-rays taken:** ______________ **Date of last dental visit:** ______________

**Check if you have had any of the following:** **Bad Breath** ☐ **Bleeding Gums** ☐ **Clicking or popping jaw** ☐

**Food Collection between teeth** ☐ **Grinding or clenching teeth** ☐ **Loose teeth or broken fillings** ☐

**Sensitivity to Cold or Hot** ☐ **Sensitivity to Sweets** ☐ **Periodontal Treatment** ☐ **Sensitivity to biting** ☐

**Sores or growths in mouth** ☐

## Medical History

Check if you have had any of the following:

| | | | |
|---|---|---|---|
| Aids/HIV | Circulatory Problems | Herpes (Oral) | Respiratory Disease |
| Amoxicillin Allergy | Codeine Allergy | High Blood Pressure | Shortness of Breath |
| Anaphylaxis | Cortisone Treatments | Hydrocodone Allergy | Sinus Problems |
| Anemia | Crohn's Disease | Jaw Pain | Stomach Problems |

| | | | |
|---|---|---|---|
| Anorexia/Bulimia | Diabetes | Keflex Allergy | Stroke |
| Arthritis | Drug Allergies | Kidney Disease | Sulfa Drug Allergy |
| Artificial Joints | Epilepsy | Latex Allergy | Surgical Implants |
| Aspirin Allergy | Erythromycin Allergy | Liver Disease | Swelling of Feet or Ankles |
| Asthma | Glaucoma | Material Allergies | Tetracycline Allergy |
| Back Problems | Growths | Mito Valve Prolapse | Thyroid Disorder |
| Blood Thinners/Coumadin | Head Injuries | Pacemaker | Tobacco Habit |
| Cancer | Headaches | Penn Allergy | Tonsillitis |
| Ceclor Allergy | Heart Conditions | Persistent Cough | Tuberculosis |
| Chemical Dependency | Heart Surgery | Pre- Med | Tumors |
| Chemotherapy/Radiation | Hemophilia/Abnormal Bleeding | Psychiatric Care | Ulcerative Colitis |
| Cipro Allergy | Hepatitis A or B | Rapid Weight Gain/Loss | |

Medical History on File:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________

- Name of Physician: ______________________________ Phone: ________________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

Women are you pregnant? ____________ Are you nursing? ____________ Taking Oral Contrceptive? ____________

## LIST OF MEDICATIONS

1. ________________ 2. ________________ 3.________________

4.________________ 5. ________________ 6.________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ **Date:** ________________

**Signature of patient, parent or guardian**

______________________________

**Please print patient's name**

______________________________

**Please print parent or legal guardians name**