F. Neal Pylant, D.M.D.
375 Hawthorne Lane, Athens, Georgia 30606
Office: 706-543-0026 GA WATS: 1-800-822-4632
Fax: 706-543-9801

DATE: _____ Name_____ Marital Status_____ Age_____ Sex____
Last First M.I.
Phone: (H)_____ Phone: (W)_____ Phone: (C)_____

E-mail address: _____

Place of Employment_____ SSN_____ Date of Birth _____

Home Address_____ City_____State_____ Zip_____

Mailing Address_____ City_____State_____ Zip_____

Name of Spouse/Guardian_____ Place of Employment_____ SSN_____

DENTAL Insurance Carrier_____ Policyholder's Name_____

MEDICAL Insurance Carrier_____ Policyholder's Name_____

Referring Dentist_____Physician_____ Referring Patient_____

Is there anyone we can thank for your referral? Who? _____

In case of an emergency please call_____ Phone:_____

DENTAL HISTORY:

DO NOT WRITE IN THIS SPACE

Yes_____ No_____ 1. Are there now any injuries or inflamed areas in or around your mouth?

Yes_____ No_____ 2. Do you know of any growths or sore spots in your mouth?

Yes_____ No_____ 3. Is any part of your mouth sore to pressure or irritants (cold, sweets, etc.)?
If so, where?_____
_____

4. What is your present dental complaint?_____
_____

5. Approximate date of last dental complaint _____
a) Was all treatment completed? _____
b) Date teeth were last cleaned _____
c) Date last full mouth X-Rays were taken _____

Yes_____ No_____ 6. Do you think your teeth will last a lifetime?

Yes_____ No_____ 7. Are you satisfied with your smile?

8. If you could change anything about your mouth what would it be?
_____
_____
_____

Yes_____ No_____ 9. Is there anything we should know about you that would help make your visits more comfortable?_____
_____

Name _____
Last First M.I.

MEDICAL HISTORY:

DO NOT WRITE IN THIS SPACE

Yes_____ No_____ 1. Has there been any change in your general health within the past year?
If yes, explain _____

2. Date of last physical examination _____

Yes_____ No_____ 3. Are you now under the care of a physician? _____
If so, what is the condition being treated? _____

Yes_____ No_____ 4. Have you had any serious illness or operation in the past ten (10) years?
If yes, what was the illness or operation? _____

5. Do you have any of the following diseases or problems?

Yes_____ No_____ (a) Rheumatic fever or rheumatic heart disease, scarlet fever?
Yes_____ No_____ (b) Cardiovascular disease (heart trouble, heart attack, irregular heartbeat, high blood pressure, arteriosclerosis, stroke, congenital heart lesions)?
Yes_____ No_____ (c) Heart murmurs, mitral valve prolapse?
Yes_____ No_____ (d) Do you take antibiotics prior to dental appointments for heart problems?
Yes_____ No_____ (e) Do take antibiotics prior to dental appointments for joint replacements?
Yes_____ No_____ (f) Sinus trouble, asthma, hay fever, emphysema, allergies, T.B.?
Yes_____ No_____ (g) Fainting spells, seizures, anxiety, depression?
Yes_____ No_____ (h) Have you or anyone in your families had diabetes?
(Relationship) _____
Yes_____ No_____ (i) Hepatitis, jaundice, or liver disease?
Yes_____ No_____ (j) Arthritis/Fibromyalgia/Lupus; any artificial joints?
Yes_____ No_____ (k) Stomach ulcers/Reflux?
Yes_____ No_____ (M) Venereal Disease (Aids, Syphilis, HIV, etc.)?
Yes_____ No_____ Other: _____

Yes_____ No_____ 6. Do you use Tobacco? What type? _____
Yes_____ No_____ 7. Any alcohol use? Weekly usage? _____
Yes_____ No_____ 8. Have you had surgery or X-Ray treatment for a tumor, growth, cancer, or other condition?
Yes_____ No_____ 9. Are you taking any drug, medicine, pills, or vitamin supplements?
List _____

10. Are you allergic or have you reacted adversely to:

Yes_____ No_____ (a) Local anesthetic
Yes_____ No_____ (b) Penicillin or other antibiotic (sulfa)
Yes_____ No_____ (c) Barbiturates, sedatives, or sleeping pills
Yes_____ No_____ (d) Aspirin, Tylenol
Yes_____ No_____ (e) Pain Medications (ex. codeine)
Yes_____ No_____ (f) Latex, Iodine
Yes_____ No_____ (g) Other _____
Yes_____ No_____ 11. Do you have any disease, condition, or problem not listed above that you think should be known? _____
Yes_____ No_____ 12. (Women) Are you pregnant?
Yes_____ No_____ (a) Any hormone changes? _____

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable to diagnose my oral problem. I authorize the release of my information to my physician, general dentist, or any third party which may be necessary. I will assume responsibility with those procedures and authorize Dr. Pylant to contact the appropriate parties.

Patient's Signature _____ Date _____

Minors: I accept responsibility for payment of fees for procedures done by Dr. Pylant and his staff.
Parent / Guardian (circle one) _____ Date _____

Visit Our Web Site At: www.athensperio.com
Email Us At: drpylant@bellsouth.net