S. ALBERT CAVES, D.M.D.
5900 RIVER ROAD, SUITE 302 • COLUMBUS, GEORGIA 31904 • 706-571-0079

Welcome to Dr. Caves' Office!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: _____ / _____ / _____ Age: _____ Social Security # _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Residence Address: _____
Street City State Zip

Billing Address (if different from above): _____
Street / PO Box City State Zip

Home Phone #: (_____) _____ Cell/Other #: (_____) _____ Work Phone #(_____) _____ Ext. _____

Driver's License #: _____ Where & when are best times to reach you? _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer Address: _____
Street / PO Box City State Zip

Do you have dental insurance?: ☐ Yes ☐ No

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____

Work Phone #: (_____) _____ Home Phone #: (_____) _____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: _____ / _____ / _____ Social Security #: _____

Employer: _____ Work Phone #: (_____) _____ Ext. _____ Driver's License #: _____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Would you like fresher breath? ☐ Yes ☐ No Whiter Teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

CONTINUED ON BACK

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physicians Name: _____

Address: _____
Street

_____
City State Zip

Phone #: (_____) _____ Date of last visit: _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Do you have, or have you had, any of the following?

Abnormal Bleeding ☐ Yes ☐ No	Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attach/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Asprin ☐ Yes ☐ No	Dental Anesthetics ☐ Yes ☐ No	Latex ☐ Yes ☐ No	Sulfa Drugs ☐ Yes ☐ No
Barbiturates ☐ Yes ☐ No	Erythromycin ☐ Yes ☐ No	Penicillin ☐ Yes ☐ No	Tetracycline ☐ Yes ☐ No
Codeine ☐ Yes ☐ No	Jewelry / Metals ☐ Yes ☐ No	Sedatives ☐ Yes ☐ No	Other ☐ Yes ☐ No

Please list anything that causes allergic reactions: _____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services that I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, and also responsible for any copayment and deductible that my insurance does not cover.
I have received a copy of this offices Notice of Privacy Practices.

_____
Signature Date

Medical History Update

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date