# ROBERT J. O'DONNELL, DDS

*Family & Cosmetic Dentistry*

**Robert J. O'Donnell, DDS • Robert A. Grollman, DDS**
**134 North Main Street • Alpharetta, GA 30009**
**(770) 664-6245 • Fax (770) 664-8928**

**Date:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Birthdate:** _____ **Age:** _____ **SS#:** _____

❑ **Married** ❑ **Single** **Email:** _____

**Special Interests:** _____

**Company Name/School:** _____

**Work Address:** _____ **Phone:** _____

**Spouse's Name:** _____

**Spouse's Occupation:** _____

**Work Address:** _____ **Phone:** _____

**Person Responsible for account:** _____

**Dental Insurance Company:** _____

**Last Dental Visit:** _____

**Person to contact in case of emergency:** _____

**Relationship to you:** _____ **Phone:** _____

**Referred by:** _____

*Please complete Health History on other side.*

# HEALTH HISTORY

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital in the past 2 years? ..... YES NO
5. Have you been under the care of a medical doctor during the past 2 years? ..... YES NO

   Physician's Name: _____

   Address: _____ Phone #: _____
6. Have you taken any medicine or drugs during the past 2 years? ..... YES NO

   Are you now taking any medications, drugs, or pills? ..... YES NO

   If yes, please list: _____
7. Are you allergic or have you reacted adversely to any of the following medications? ..... YES NO

| | | | |
|---|---|---|---|
| Aspirin | Nitrous Oxide | Valium | Local Anesthetic |
| Darvon | Erythromycin | Scopolamine | (Novocaine or Xylocaine) |
| Codeine | Tetracycline | Penicillin | Sleeping Pills |
| Demerol | Percodan | Other Antibiotics | (Nembutal/Seconal) |

8. Are you aware of being allergic to any other medications or substances? ..... YES NO

   If yes, please list: _____
9. Circle any of the following which you have had or presently have:

| | | |
|---|---|---|
| Heart Failure | Emphysema | Hepatitis A ( infectious) |
| Heart Disease or Attack | Cough | Hepatitis B (serum) |
| Angina Pectoris | Tuberculosis (TB) | Liver Disease |
| High Blood Pressure | Asthma | Yellow Jaundice |
| Heart Murmur | Hay Fever | Blood Transfusion |
| Rheumatic Fever | Sinus Trouble | Drug Addiction |
| Congenital Heart Lesions | Allergies or Hives | Hemophilia |
| Scarlet Fever | Diabetes | Venereal Disease (Syphilis, Gonorrhea) |
| Heart Pacemaker | Thyroid Disease | Cold Sores |
| Artificial Heart Valve | X-ray or Cobalt Treatment | Fever Blisters |
| Heart Surgery | Chemotherapy (Cancer, Leukemia) | Epilepsy or Seizures |
| Artificial Joints ( Hip,Knee) | Arthritis | Fainting or Dizzy Spells |
| Anemia | Rheumatism | Nervousness |
| Stroke | Cortisone Medication | Psychiatric Treatment |
| Kidney Trouble | Glaucoma | Sickle Cell Disease |
| Ulcers | Pain in Jaw Joints | Bruise Easily |
| Cosmetic Surgery | A.I.D.S. | |

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition or problem not listed? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes ❑ No If yes, what month?_____ Are you taking birth control pills? ❑ Yes ❑ No

**ABOVE INFORMATION IS TRUE**

**Patient Signature:** _____ **Date:** _____

**CONSENT:**

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

**Patient:** _____ **Date:** _____ **Witness:** _____

**Parent or responsible party:** _____ **Relationship to Patient:** _____