SHAUNA H. MITCHELL, D.D.S., P.C.
3642 FLAKES MILL ROAD, SUITE B
DECATUR, GA 30034

Patient Contact Information Update Today's Date:_____

Name_____ Date of Birth _____

Home Phone _____ Cell _____Work _____

May we contact you at work? yes or no _____ Maritial Status: _____

Street Address_____

City_____ State_____ Zip_____

Email_____ May we contact you via email? yes or no _____

SSN _____-_____-_____ Insurance Company_____

Patient Health Information Update

Has your physician or previous dentist instructed you to take antibiotics before invasive dental treatment?

_____

Are you being treated for any medical condition now? _____ If so, what?_____

Have you been hospitalized within the last 3 years?_____ If so, why?_____

Have you had or been treated for (circle any that apply) *Multiple Myeloma, Metastatic Cancer, Paget's Disease or Osteoporosis.*

Do you or have you ever taken oral *(Actonel, Boniva, Fosemax, Skelit, Didrorel)* or IV *(AREDIA, ZOMETA) Bisphosphonates*? Yes or No

List any medications you take and its purpose. (including over-the-counter & herbal)_____

_____

Are you allergic to any medication?_____ If so, what?_____

Please write ALL CHANGES in your health history since the last time you filled out Health History Form. Please provide accurate and detailed changes to your health along with the name of the treating doctor, the hospital and the doctor contact information. This will help us provide you with personalized dental care.

_____

_____

To the best of my knowledge, the information is complete and correct. I understand that it is my responsibility to inform my dentist, if I or my minor child, ever have a change in health.

_____ _____
Signature (Parent if minor) Date

_____ _____
Print Full Name Dentist Signature