Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential) Today's Date:_____

Legal Name _____Wishes to be called _____

Soc. Sec. # _____ Birthdate_____ Home Phone_____ Cell #_____

Address_____ City_____ State _____ Zip _____

Email _____

When confirming appointments how do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text Message

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City_____ State_____ Zip_____

Spouse or Parent's Name _____ Phone_____

How did you hear about our office? (Check All That Apply)
❑TV ❑Google ❑ Website ❑Yellow Pages ❑ Brochure ❑ Referred by Family/Friend:_____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party (if different from above)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Contact # _____ Birthdate _____

Employer _____ Work Phone_____ SSN # _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

Dental Insurance Information: If you do **not** have dental insurance proceed to the next page->

Name of Primary Carrier_____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer_____

Insurance Company_____ Group#_____ Policy/ID#_____

Ins. Co. Address _____ City_____ State_____ Zip_____

EAST MARIETTA family dentistry

Patient Medical History

Physician name/Office _____ City_____ Office Phone_____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain: _____ _____	❑	❑
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medications are you taking? _____ _____	❑	❑
4. Are you currently taking or have you ever taken osteoporosis medications in the past? If so, how long? _____ Which ones? _____	❑	❑
5. Do you use Tobacco?	❑	❑
6. Do you use controlled substances or recreational drugs?	❑	❑

7. Are You Allergic to:	Yes	No
Local Anesthetics (e.g.novocaine)	❑	❑
Penicillin	❑	❑
Other Antibiotics_____	❑	❑
Sulfa Drugs	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Ibuprofen	❑	❑
Tylenol	❑	❑
Codeine	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other_____	❑	❑

8. *Women Only:*

a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

10. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting	❑	❑
Seizures	❑	❑
Low Blood Pressure	❑	❑
Epilepsy / Convulsions	❑	❑
Cancer	❑	❑
Radiation Therapy	❑	❑
Diabetes	❑	❑
Kidney Diseases	❑	❑
AIDS or HIV Infection	❑	❑
Thyroid Problem	❑	❑
Sight Impaired	❑	❑
Hearing Impaired	❑	❑
Heart Disease	❑	❑
Asthma	❑	❑
Congestive Heart Failure	❑	❑
Cardiac Pacemaker	❑	❑
Angina	❑	❑
Frequently Tired	❑	❑
Anemia	❑	❑
Stroke	❑	❑
Heart Murmur	❑	❑
Mitral Valve Prolapse	❑	❑
By-Pass Operations	❑	❑
Heart Stents	❑	❑
Joint Replacement or Implant: If so, When?_____	❑	❑
Do you need to take antibiotics prior to dental care?	❑	❑
Sexually transmitted Disease	❑	❑
Stomach Troubles / Ulcers	❑	❑
Vertigo	❑	❑
Neck Pain	❑	❑
Back Pain	❑	❑
Chest Pains	❑	❑
Easily Winded	❑	❑
Emphysema / COPD	❑	❑
Hay Fever / Allergies	❑	❑
Glaucoma	❑	❑
Recent Weight Loss	❑	❑
Liver Disease	❑	❑
Arthritis	❑	❑
Tuberculosis	❑	❑
Hepatitis / Jaundice	❑	❑
Other _____		

Patient Dental History

Name of Previous Dentist/Location _____ Date of last Exam/Cleaning_____

	Yes	No
10. Do your gums bleed while brushing or flossing?	❑	❑
11. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
12. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
13. Do you feel pain in any of your teeth?	❑	❑
14. Do you have any sores or lumps in or near your mouth?	❑	❑
15. Have you had any head, neck or jaw injuries?	❑	❑
16. Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑

	Yes	No
1. Do you have frequent headaches?	❑	❑
2. Do you clench or grind your teeth?	❑	❑
If yes, do you wear a night guard?	❑	❑
3. Do you bite your lips or cheeks frequently?	❑	❑
4. Have you ever had any difficult extractions in the past?	❑	❑
5. Have you ever had any prolonged bleeding following extractions?	❑	❑
6. Have you had any orthodontic treatment?	❑	❑
7. Do you wear dentures or partials?	❑	❑
If yes, date of placement_____		
8. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
9. Do you like your smile?	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. Balances older than 90 days will be subject to a monthly finance charge of 1.5%. I agree to be responsible for payment of all service rendered for myself and on my behalf of my dependents.

SIGNATURE OF PATIENT_____/_____

(RESPONSIBLE PARTY IF PATIENT IS A MINOR) date

t 770.977.1632 f 770.578.8140 The Summit Building 3823 Rowell Road, Suite 104 Marietta, Georgia 30062
www.EastMariettaFamilyDentistry.com

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-today healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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I authorize release of any information relating to this claim. I hereby authorize payment directly to the above named doctor of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment.

_____

PRINT NAME OF INSURED

_____

SIGNED NAME OF INSURED

_____

DATE SIGNED

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I/WE CERTIFY THAT ALL INFORMATION IS TRUE AND COMPLETE. THIS REQUEST IS FOR A CREDIT AGREEMENT WITH *EAST MARIETTA FAMILY DENTISTRY*. I/WE AGREE TO PAY THE AMOUNT INVOLVED IN FULL. IN THE EVENT *EAST MARIETTA FAMILY DENTISTRY* EXTENDS CREDIT TO THE APPLICANT, THE APPLICANT AGREES THAT EAST MARIETTA FAMILY DENTISTRY MAY ASSESS INTEREST AND SERVICE CHARGES ON THE PURCHASERS OUTSTANDING BALANCE AT A RATE OF 1.5% PER MONTH (18% PER ANNUM). I/WE FURTHER AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING COSTS OF A COLLECTION AGENCY IF THE ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, AND INCLUDING A 15% ATTORNEY'S FEE AND COURT COSTS IN THE EVENT THIS BALANCE IS TURNED OVER TO AN ATTORNEY. IT IS AGREED THAT THIS AGREEMENT WILL BE GOVERNED UNDER THE LAW OF THE STATE OF GEORGIA. EAST MARIETTA FAMILY DENTISTRY HAS THE OPTION OF PURSUING AN ACTION UNDER THIS AGREEMENT IN ANY COURT COMPETENT JURISDICTION IN THE STATE OF GEORGIA AND I/WE CONSENT TO JURISDICTION IN THE STATE OF GEORGIA. IF MY/OUR BUSINESS IS A CORPORATION, I/WE AGREE TO BE PERSONALLY RESPONSIBLE AS GUARANTOR FOR ANY DEBT MADE BY THE CORPORATION. I/WE HAVE RECEIVED A COPY OF THIS AGREEMENT.

DATE

PRINT NAME

AUTHORIZED SIGNATURE

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