



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 _____



Patient Medical History

Physician name/Office _____ City _____ Office Phone _____

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | 7. Are You Allergic to: | Yes | No |
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medications are you taking?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | Other Antibiotics _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking or have you ever taken osteoporosis medications in the past?
If so, how long? _____
Which ones? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use Tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances or recreational drugs? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Ibuprofen | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Tylenol | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 8. <i>Women Only:</i> | | |
| | | | a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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



Patient Dental History

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

	Yes	No		Yes	No
10. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	1. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you clench or grind your teeth? If yes, do you wear a night guard?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	3. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever experienced any of the following problems in your jaw?			7. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

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



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-to-day 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: _____



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



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
