PROSTHODONTICS ATLANTA

5555 Peachtree Dunwoody Road
The Medical Quarters, Suite 240
Atlanta, GA 30342

Patient Information

Name:_____ Preferred Name:_____

Date:_____ Employer:_____

Gender:_____ Marital Status:_____ E-Mail:_____

Social Security Number:_____ Date of Birth:_____

Phone Numbers: Home:_____ Work:_____ Cell:_____

Address:_____ City:_____ Zip Code:_____

Please list any family members that are current patients here:_____

Health Information

Who may we thank for referring you?_____

Have you ever had any of the following? Please check all that apply.

☐ Allergies_____	☐ Excessive Bleeding	☐ Kidney Disease	☐ Stomach Problems
☐ Allergy Penicillin	☐ Fainting	☐ Liver Disease	☐ Stroke
☐ Allergy Codeine	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Anemia	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Artificial Joints	☐ Head Injuries	☐ Pregnancy_____	☐ Venereal Disease
☐ Asthma	☐ Heart Disease	Due:_____	☐ Other (please list)
☐ Blood Disease	☐ Heart Murmur	☐ Radiation Treatment	_____
☐ Cancer_____	☐ Hepatitis	☐ Respiratory Problem	_____
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever	_____
☐ Dizziness	☐ HIV	☐ Rheumatism	_____
☐ Epilepsy	☐ Jaundice	☐ Sinus Problems	_____

Have you ever had any complications following dental treatment? ☐ Y ☐ N

If yes, explain:_____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Y ☐ N

If yes, explain: _____

Are you now under the care of a physician: ☐ Y ☐ N

If yes, explain:_____

Name of physician:_____ Phone:_____

Do you have any problems that need further clarification: ☐ Y ☐ N

If yes, explain:_____

Please list any medications you are currently taking?_____

Do you smoke?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or health conditions, I will inform the doctor before or during my next appointment.

_____ _____

Signature of Patient or Guardian Date

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Dental History

Patient Name:_____ Date:_____

Reason for today's visit:_____

_____

Date of last dental visit:_____ Last Dental X-ray:_____

Please indicate if you have any of the following symptoms and/or habits:

- ☐ Bad Breath
- ☐ Latex allergy
- ☐ Bleeding Gums
- ☐ Lip or cheek biting
- ☐ Blisters on lips or mouth
- ☐ Loose teeth or broken fillings
- ☐ Burning Sensation on tongue
- ☐ Mouth breathing
- ☐ Chew on one side of mouth
- ☐ Mouth pain, brushing
- ☐ Cigarette, pipe or cigar smoking
- ☐ Orthodontic treatment
- ☐ Clicking or popping jaw
- ☐ Pain around ear
- ☐ Dry mouth
- ☐ Periodontal treatment
- ☐ Fingernail biting
- ☐ Sensitivity to cold
- ☐ Food collection between the teeth
- ☐ Sensitivity to heat
- ☐ Grinding Teeth
- ☐ Sensitivity to sweets
- ☐ Gums swollen or tender
- ☐ Sensitivity when biting
- ☐ Headaches
- ☐ Jaw pain or tiredness
- ☐ Sores or growths in your mouth

Do you floss?_____ How Often?_____

How often do you brush?_____

Are you happy with your smile?_____

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Insurance Policies

Patients who carry dental insurance understand that all dental services furnished are charged directly to them at the time services are rendered. As a courtesy, this office will assist in the preparation of insurance forms and provide any necessary documentation to aid our patients in pre-determination from their insurance carrier. We are not a participating provider on any insurance plan. It is the responsibility of the patient to verify insurance coverage with their carrier.

I have read and understand this policy. _____ _____

Patient Signature Date

Patient Name:_____

Primary Insurance:

Name of Insured:_____

If insured different from patient: Date of Birth:_____

Social Security Number:_____

Employer:_____

Insurance plan name:_____

Address:_____ City_____

State:_____ Zip Code:_____

Member ID:_____

Group Name:_____ Group Number:_____

Phone Number:_____

Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance:

Name of Insured:_____

If insured different from patient: Date of Birth:_____

Social Security Number:_____

Employer:_____

Insurance plan name:_____

Address:_____ City_____

State:_____ Zip Code:_____

Member ID:_____

Group Name:_____ Group Number:_____

Phone Number:_____

Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

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Responsible Party Information

(Please complete only if different from the patient information)

Name:_____ Family Status:_____

Social Security Number:_____ Date of Birth:_____ Sex:_____

Phone Numbers: Home:_____ Work:_____

Address:_____ City:_____ St:_____ Zip Code:_____

Employer Name:_____

Office Policies

Appointments: Appointment times are reserved for you. We make every effort to reach you to remind you of your appointment, however, your appointment is your responsibility. We do require a 24-hour notice prior to canceling an appointment.

Payments: As a condition of your treatment by our office, payment is due in full at the time services are rendered. We are a fee for service office and therefore depend on reimbursement from patients for the cost incurred in their care.

Treatment Plan Estimates: Treatment plan estimates are just that. We will make every attempt to plan accurately, but unanticipated situations do arise and can effect previously planned treatment. Patients will be notified of applicable fees before services are rendered. A fee estimate is effective for 90 days.

Patient Permission: In consideration for the professional services rendered to me, or at my request, by Dr. Smith, I agree to pay the fee for said services to Dr. Smith or his assignee at the time services are rendered. I grant my permission to Dr. Smith, or his assignee, to telephone me at home or my place of employment to discuss matters related to this form.

Health Insurance Portability and Accountability ACT (HIPPA)
I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

I do _____ or do not _____ agree to have my images used for educational purposes.

_____ _____
Signature of Patient or Guardian Date

Print Name_____

Emergency Contact:

_____ _____
Name Phone Number

I give Dr. Smith permission to discuss my case
and/or financial arrangements with the contact person.

_____ _____
Signature Date