Patient's signature (or parent if patient is a minor)

Date \_

## Phone 678-817-0600 • FAX 678-817-0601

## PERSONAL & CONFIDENTIAL INFORMATION

Street			Nickname			Date of Birth			
Nearest relative not living with you	Name		Age		Sex	SSN#			
Relationship	Street		City		Zip	County			
Relationship	Home Phone	Total Service Control of the Control	Alternate Phone						
Employer									
Person responsible for fees DOB SS# Referred by Have X-rays been sent Drivers License # Drivers Licens									
Person responsible for fees DOB Have X-rays been sent Brave any of your relatives been treated by us Drivers License # D									
Have X-rays been sent									
MEDICAL HISTORY (Please Read and Answer Carefully)  On you smoke?  Have you ever had orthodontics?  Pyes No List the medicines you are allergic to:  Are you allergic or sensitive to any medicines?  Pyes No List the medicines you are allergic to:  Are you allergic to Penicillin?  Pyes No No List the medicines you are allergic to:  Are you under the care of a Physician now?  Pyes No List the medicines you are taking:  Are you been treated by a Physician recently?  Pyes No List the medicines you are taking:  Are you taking any medicines now?  Pyes No No List the medicines you are taking:  Are you taking any medicines now?  Pyes No	Person responsible for fe	90S	DOB			SS#	*****************		
MEDICAL HISTORY (Please Read and Answer Carefully)  Do you smoke?	Referred by			F	lave X-rays I	been sent			
Do you smoke?   Yes   No	Have any of your relative	es been treated by us		nii sali	Drivers Lie	cense #	***************************************		
Have you ever had orthodontics?	on say Thousa	MEDICALI	HISTORY (Please Rea	ad and Ans	wer Carefull	y)			
Are you ever had orthodontics?	Do you smoke?		☐ Yes ☐ No		Name of 0	Orthodontist			
Are you allergic to Penicillin?		dontics?	☐ Yes ☐ No		List the m	edicines you are	allergic to:		
Are you under the care of a Physician now?	Are you allergic or sensit	tive to any medicines?	☐ Yes ☐ No						
Have you been treated by a Physician recently?			☐ Yes ☐ No						
Ave you ever been admitted to the hospital?	are you under the care o	of a Physician now?	☐ Yes ☐ No						
Averyou ever been admitted to the hospital?	lave you been treated b	y a Physician recently?	☐ Yes ☐ No		List the m	edicines you are	taking:		
Please Circle Any of the Following Which You Have Had: (If none, circle NONE), and sign in Space Below  Arthritis Seizures Glaucoma Problems with tooth extractions Heart Trouble AIDS Hepatitis Thyroid Problems Heart Murmur Difficulty Breathing Bleeding Problems Malignancy Hehumatic Fever Lung Trouble Nervous Problems NONE High Blood Pressure Liver Trouble Diabetes Ow Blood Pressure Jaundice Asthma Kidney Trouble Peptic or Stomach Ulcers BP Pulse Wgt.  FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED Please indicate method of payment desired: Cash Check Charge Card Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance ompany. You will be responsible for all collection costs, attorney fees or court costs.  Signature: Signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment his doctor named of the benefits otherwise payable to me.	lave you ever been adn	nitted to the hospital?	☐ Yes ☐ No				-		
Please Circle Any of the Following Which You Have Had: (If none, circle NONE), and sign in Space Below Arthritis Seizures Glaucoma Problems with tooth extractions Heart Trouble AIDS Hepatitis Thyroid Problems Heart Murmur Difficulty Breathing Bleeding Problems Malignancy Rheumatic Fever Lung Trouble Nervous Problems NONE High Blood Pressure Liver Trouble Diabetes Ow Blood Pressure Jaundice Asthma Kidney Trouble Peptic or Stomach Ulcers BP Pulse Wgt.  FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED Please indicate method of payment desired: Cash Check Charge Card Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment is syour responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees or court costs.  Signature: Signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment his doctor named of the benefits otherwise payable to me.	re you taking any medic	cines now?	☐ Yes ☐ No						
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Heart Trouble AIDS Hepatitis Thyroid Problems Heart Murmur Difficulty Breathing Bleeding Problems Malignancy Rheumatic Fever Lung Trouble Nervous Problems NONE High Blood Pressure Liver Trouble Diabetes Low Blood Pressure Jaundice Asthma Anemia Kidney Trouble Peptic or Stomach Ulcers BP Pulse Wgt.  FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED Please indicate method of payment desired: Cash Check Charge Card Insurance: Dental Yes No Medical Yes No  Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees or court costs.  This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment this doctor named of the benefits otherwise payable to me.  Signature:	Please Circle Any of the	Following Which You Hav	e Had: (If none, circle	NONE), a	nd sign in Sp	pace Below			
Heart Murmur Difficulty Breathing Bleeding Problems Malignancy Rheumatic Fever Lung Trouble Nervous Problems NONE  High Blood Pressure Liver Trouble Diabetes Low Blood Pressure Jaundice Asthma Rhemia Kidney Trouble Peptic or Stomach Ulcers BP Pulse Wgt  FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED  Please indicate method of payment desired:	Arthritis	Seizures	Glaucoma		Problems	with tooth extrac	tions		
Rheumatic Fever Lung Trouble Nervous Problems NONE  digh Blood Pressure Liver Trouble Diabetes  Asthma  Kidney Trouble Peptic or Stomach Ulcers BP Pulse Wgt.  FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED  Please indicate method of payment desired: Cash Check Charge Card  Insurance: Dental Yes No Medical Yes No  Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees or court costs.  This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment his doctor named of the benefits otherwise payable to me.  Signature:			Hepatitis		Thyroid Pr	oblems			
Liver Trouble Diabetes Low Blood Pressure Jaundice Asthma  Anemia Kidney Trouble Peptic or Stomach Ulcers BP Pulse Wgt.  FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED  Please indicate method of payment desired: Cash Check Charge Card Insurance: Dental Yes No Medical Yes No  Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees or court costs.  This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment his doctor named of the benefits otherwise payable to me.  Signature:						y			
Ashma Anemia    Ashma   Peptic or Stomach Ulcers   Pulse   Pulse   Wgt.		_		ns	NONE				
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FEES ARE DUE AND PAYABLE AT TIME SERVICE IS RENDERED  Please indicate method of payment desired:				ch Ulcers	BP	Pulsa	Wat		
Please indicate method of payment desired:							1191.		
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company. You will be responsible for all collection costs, attorney fees or court costs.  This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment his doctor named of the benefits otherwise payable to me.  Signature:				-					
his doctor named of the benefits otherwise payable to me.  Signature:						net paid let by	your mouranes		
his doctor named of the benefits otherwise payable to me.  Signature:	This signature on file is n	ny authorization for the re	lease of information of	cossan to	nrocoss mi	coloim I horoby	authoriza paymont to		
				cessary ic	process my	Claim. Thereby	aumonze payment to		
			Signaturo:						
			Signature.						
		and answered the aboven answered to my satisfa	ve questions correct	y. I ackno	wledge that	my questions, if			

Date of Last Dental Visit Last D	ental Clar	anina	Last Full Mouth X-rays		
What was done at your last dental visit?	ond Cie	amy _	Last ruii Mouth X-rays		
General Dentist's Name					
Address			State Zip		
Telephone					
					-113
Do either of your parents wear dentures?					
How often do you brush your teeth?	_ How o	ften do y	ou floss?		
What other dental aids do you use? (Interplak, toothpick, e	tc.)				
Do you have any dental problems now?	Yes	No			
If yes, please describe:			F-800	N/TENGE	
Are any of your teeth sensitive to:			Have you ever had:	- Y	r lan
Hot or ∞ld?		No	Orthodontic treatment?	Yes	No
Sweets?		No	Oral surgery?		No
Biting or Chewing?  Have you noticed any mouth odors or	Yes	No	Periodontal treatment?		No
bad tastes?	Yes	No	Your teeth ground or the bite adjusted? A bite plate or mouth guard?	Yes	No
Do you frequently get cold sores, blisters or any	100	,,,,	A serious injury to the mouth or head?		No
other oral lesions?	Yes	No	If so, please describe, including cause		
Do your gums bleed or hurt?	Yes	No			
Have your parents experienced gum disease		100000	Have you experienced:		
or tooth loss?	Yes	No	Clicking or popping of the jaw?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No	Pain? (joint, ear, side of face) Difficulty in opening or closing the mouth?	Von	Ma
Does food tend to become caught in	103	140	Difficulty in chewing on either side of the mouth?	Yes	No
habuana yaya ta ath 2	Yes	No	Headaches, neckaches or shoulder aches?	Yes	
If yes, where?			Sore muscles (neck, shoulders)?	Yes	No
Do you:		22	Are you satisfied with your teeth's appearance?	Yes	No
Clench or grind your teeth while awake or asleep? Bite your lips or cheeks regularly?	Yes		Would you like to keep all of your teeth all of your	V	
Hold foreign objects with your teeth?	Yes		life?	Yes	ИО
(pencils, pipe, pins, nails, fingernails)			Do you feel nervous abut having dental treatment?	Yes	No
Mouth breathe while awake or asleep?	Yes		If so, what is your biggest concern?		
Have tired jaws, especially in the morning?					
Smoke/chew tobacco?	Yes	ИО	Have you ever had an upsetting dental experience?	Yes	No
		124	If yes, please describe		
Primary	nsura	ance I	nformation		
Name of Insured:			Is insured a patient?	Yes	O No
Insured's Birth Date:ID	#:	st	Group#:		
Insured's Address:			Cey State Zp Code		
insured's Employer Name:					
Address:					
Patient's relationship to insured:   Self   Sp	ouse (	□ Child	d Other		
Insurance Plan Name and address:					
Secondary					
Name of Insured:			Is insured a patient?	es (	⊃ No
Insured's Birth Date:IE	)#:F#	st .			
Insured's Address:			Cey State Zp Code		
insured's Employer Name:			Cry State Zip Code		
Address:					
Patient's relationship to insured:   Self  Sp	ouse	Chik	Cry State Zip Code		
Insurance Plan Name and address:					