

GEORGIA SMILES
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<p align="center">Today's Date _____</p> <p align="center"><u>PATIENT'S INFORMATION</u></p> <p>First Name & Middle Initial _____</p> <p>Last Name _____</p> <p>Cell phone# _____</p> <p>Home Phone# _____</p> <p>Work phone# _____ Ext. _____</p> <p>Email address _____</p> <p>Street Address _____</p> <p>City _____</p> <p>Zip code _____</p> <p>Social Security# _____</p> <p>Date of Birth (MM/DD/YYYY) _____</p> <p>Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married</p> <p>Sex <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Employer _____</p> <p>Occupation _____</p> <p>Employer address _____</p>	<p>Is the patient the SAME person as the policy holder? (circle Yes or No) If "Yes" then skip the rest of this box. If "No" what is the relationship of the patient to the policy holder? (circle one) Husband Wife Son Daughter Other _____</p> <p align="center"><u>POLICY HOLDER'S INFORMATION</u></p> <p>First Name & Middle Initial _____</p> <p>Last Name _____</p> <p>Cell phone# _____</p> <p>Home Phone# _____</p> <p>Work phone# _____ Ext. _____</p> <p>Email address _____</p> <p>Street Address _____</p> <p>City _____</p> <p>Zip code _____</p> <p>Social Security# _____</p> <p>Date of Birth (MM/DD/YYYY) _____</p> <p>Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married</p> <p>Sex <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Employer _____</p> <p>Occupation _____</p> <p>Employer address _____</p>
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IN CASE OF AN EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND NOT LIVING WITH:		
Name _____	Phone _____	Relationship _____

HOW WERE YOU REFERRED TO US?

Friend of Family Member: Name _____

Insurance Internet Flyer or Coupon Drive By Other _____

<p>I the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial responsibility. I also authorize release of any information relating to my insurance claims and the assignment of any and all dental insurance benefits directly to Dr. Taher. I acknowledge that all non-current balances on accounts over sixty days will be charged a service fee of 2% per month (21% annually) on the unpaid balances and that my credit information may be accessed. At this time any professional courtesy and/or budget account balances may be added back to the account. Any additional costs incurred in collecting this account, including court costs and attorneys fees, will be added to my balance due.</p>
<p>SIGNATURE OF PERSON RESPONSIBLE FOR THE PAYMENT OF THE ACCOUNT X _____</p>

PLEASE TURN THIS SHEET OVER AND FILL OUT THE MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. When did you last receive dental treatment? _____
2. What type of treatment? _____
3. Previous Dentist _____
City, State _____
4. Have you worn braces? Y* N
5. Do you have a family history of periodontal disease? Y
N
6. Have you ever had a gum surgery? Y N
7. Do you have dentures, partial dentures, bridges,
or crowns? Y N
If yes, when were they made? _____
8. Do you chew on one side of your mouth? Y N
9. Do you get clicking or popping in your jaw? Y N
10. Do you get jaw pain or tenderness? Y N
11. Do you or have been told that you grind your teeth? Y N
12. Do you bite your nail or ice chewing? Y N
13. Are you a mouth breather? Y N
14. Have you had any problems associated with any previous
dental treatment or past dental experience? Y N
15. Are you under physician care? Y N
If yes, for what condition? _____
16. Date of last physical examination? _____
17. Have you been hospitalized during past three years? Y N
If so, please explain _____
18. Have you had any serious illnesses in the past
three years? Y N
If so, please explain *
19. Have you had any surgical prosthetic? Y N
(Joint, knee, implant or other replacement?) *
20. Rheumatic Fever Y* N
21. Congenital Heart Attack Y* N
22. Angina or Heart Attack Y* N
23. Heart Murmurs Y N
24. Congestive Heart Failure Y* N
25. Heart Surgery or Pacemaker Y N
26. High or Low Blood Pressure (Circle one)
27. Stroke, Asthma or Bronchitis Y N
28. Emphysema
29. Hay Fever or Sinusitis Y N
30. Diabetes Y N
31. Hyperthyroidism or Hypothyroidism (Circle one)
32. Anemia Y N
33. Do you bleed excessively when cut? Y N
34. Have you had any kidney infections? Y N

*If you answer "Y" to any of the starred questions, current American Heart Association standards may require that you take antibiotics immediately before each dental appt. If you fail to do so we will be required to reschedule your appointment unless we receive a written exemption from a physician.

Doctor's Signature

Date

35. Have you had kidney surgery? Y N
36. Hepatitis Y N
37. Venereal Disease (Within the last 10 yrs) Y N
38. Tuberculosis Y N
39. HIV Positive Y N
40. Frequent Fainting Y N
41. Liver Disease Y N
42. Arthritis Y N
43. Ulcers Y N
44. Glaucoma Y N
45. Radiation Therapy for Cancer Y N
46. Epilepsy Y N
47. Cancer Y N
48. Do you smoke? Y N
49. Do you use any other forms of tobacco? Y N

Are you currently taking any of the following drugs or medication?

50. Antibiotics Y N
51. Blood Thinners Y N
52. Steroids or Cortisone Y N
53. High Blood Pressure Medicine Y N
54. Tranquilizers Y N
55. Aspirin Y N

Please write down all the prescribed medications you are taking:

Do you have an ALLERGY or reaction to any of the following medications?

56. Local Anesthetics Y N
57. Penicillin Y N
58. Other Antibiotics Y N
59. Codeine Y N
60. Other Pain Medication Y N
61. Aspirin Y N
62. Barbiturates or Sedatives Y N
63. Other Medicine Y N

If yes, what medicine? _____

Do you have any medical problems not listed above?

If yes, please explain: _____

WOMEN ONLY

64. Are you pregnant? Y N

If yes, when are you due? _____

Patient's Signature

Date

(PARENT MUST SIGN FOR THEIR MINOR CHILDREN)