GEORGIA SMILES
780 Scenic Hwy.
Lawrenceville, GA 30046
(678) 215-1300
mygeorgiasmiles@gmail.com

Today's Date _____

PATIENT'S INFORMATION

First Name & Middle Initial _____
Last Name _____
Cell phone# _____
Home Phone# _____
Work phone# _____ Ext. _____
Email address _____
Street Address _____
City _____
Zip code _____
Social Security# _____
Date of Birth (MM/DD/YYYY) _____
Marital Status ❑ Single ❑ Married
Sex ❑ Male ❑ Female
Employer _____
Occupation _____
Employer address _____

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 _____

POLICY HOLDER'S INFORMATION

First Name & Middle Initial _____
Last Name _____
Cell phone# _____
Home Phone# _____
Work phone# _____ Ext. _____
Email address _____
Street Address _____
City _____
Zip code _____
Social Security# _____
Date of Birth (MM/DD/YYYY) _____
Marital Status ❑ Single ❑ Married
Sex ❑ Male ❑ Female
Employer _____
Occupation _____
Employer address _____

IN CASE OF AN EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

Name _____ Phone _____ Relationship _____

HOW WERE YOU REFERRED TO US?

❑ Friend or Family Member: Name _____
❑ Insurance ❑ Internet ❑ Flyer or Coupon ❑ Drive By ❑ Other _____

I the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume the financial assignment 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 Georgia Smiles. 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.

SIGNATURE OF PERSON RESPONSIBLE FOR THE PAYMENT OF THE ACCOUNT X _____

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. Blood Pressure (Circle one) High Low
27. Stroke, Asthma or Bronchitis Y N
28. Emphysema Y N
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
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. Penicillin Y N
57. Other Antibiotics Y N
58. Codeine Y N
59. Other Pain Medication Y N
60. Aspirin Y N
61. Barbiturates or Sedatives Y N
62. Other Medicine Y N

If yes, what medicine? Y N

_____

Do you have any medical problems not listed above?
If yes, please explain: _____

WOMEN ONLY

63. Are you pregnant? Y N

If yes, when are you due? _____

*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

_____
Patient's Signature Date
(PARENT MUST SIGN FOR THEIR MINOR CHILDREN)