WELCOME

Your smile is important to us.

We want to welcome you to our office. Our dental team will make every effort to make your visit pleasant. Our goal is to provide quality dental care to you and your family.

PATIENT INFORMATION RECORD

Patient: _____ **SS#:** _____ **Date of Birth:** _____

Sex: Male Female **Marital Status:** Married Single Divorced Widowed

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ Cell: _____ E-mail: _____

Employer: _____ Work Phone: _____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

Referred By: _____

RESPONSIBLE PARTY

MUST COMPLETE ALL SPACES

Person Responsible for Account (if other than Patient) _____

SS#: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____

Email address: _____ Relationship to Patient: _____

Employer: _____ Employer's Phone: _____

PLEASE READ: I understand and agree that I will be responsible for any balances for patients listed on this account. Broken appointments will be assessed and returned checks will be assessed of which I will also be responsible.

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICIES STATED ABOVE. (MUST BE SIGNED BY PERSON RESPONSIBLE FOR THIS ACCOUNT)

Responsible Party Signature: _____ **Date:** _____

PATIENT SIGNATURE: _____ **Date:** _____

West Georgia Family Dentistry

MEDICAL HISTORY

Patient's name: _____ Date: _____
Physician's name: _____Physician's Phone #: _____
Last Medical Exam: _____

Do you have any Drug Allergies or have you ever had an adverse reaction to any medication? _____
Has a physician directed you to take antibiotics prior to having dental treatment? _____ Yes _____ No
Have you had a joint replacement or heart valve replacement within the last year? _____ Yes _____No
If yes, please take your Pre-Med antibiotic as prescribed by your physician prior to your appointment.

***Please check if you have any of the following:*

___Abnormal Bleeding	___Frequent Headaches	___Orthopedic Hardware
___Anemia	___ Glaucoma	___ Pre-Med
___Angina Pectoris	___ HIV+/AIDS	___ Pace Maker
___Arthritis	___ Hay Fever	___Psychiatric Problems
___Artificial Joints	___ Heart Attack	___Radiation Therapy
___Artificial Valve	___ Heart Disease	___Rheumatic Fever
___Asthma	___ Heart Murmur	___RX- Blood Thinner
___Blood Transfusion	___ Heart Surgery	___Seizures
___Cancer-Chemo/Radiation	___ Hemophilia	___Shingles
___Congenital Heart Defect	___ Hepatitis A or B	___Sickle Cell Disease
___ Diabetes	___ Hepatitis C	___Sinus Problems
___ Difficulty Breathing	___ High Blood Pressure	___Stroke
___ Drug Abuse	___ Kidney Problems	___Thyroid Problems
___ Emphysema	___ Liver Disease	___Tuberculosis
___ Epilepsy	___ Low Blood Pressure	___Ulcers
___ Fainting Spells	___Lung/Pulmonary Disease	___Yellow Jaundice
___ Fever Blisters	___Mitral Valve Prolapse	Other_____

Are you under the care of a physician at this time? _____ Yes _____ No
If so, what conditions _____
Have you been a patient in a hospital during the past two years? _____ Yes _____ No
Have you been under a doctor's care during the past two years? _____ Yes _____ No
Have you ever responded adversely to medical or dental treatment? _____ Yes _____ No
Are you currently taking any medication? _____ If so, please list: _____
_____
Do you have any other medical conditions not mentioned above? _____ Yes _____ No
If so, please explain. _____
Do you smoke or use tobacco? _____
For women:
Are you or do you suspect that you are pregnant? _____ # of weeks _____ Are you nursing? _____

To the best of my knowledge, the information given is accurate and complete. I understand that in order to provide the best dental care, it is my responsibility to inform this office of any changes in my patient information or medical information.

Patient (or Guardian) Signature: _____Date: _____