Athens Dental Associates

Please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.

Date_____

Patient Information(Confidential) Social Security Number_____

Name_____Birthdate_____Home Phone_____

Address_____City_____State_____Zip_____

Email _____ _____Cell Phone_____

Check appropriate space : Child___Single____Married___Divorced___Widowed___Separated_____

If Student,Name of School/College_____City_____State_____

Patient or Parent's Employer_____Work Phone_____

Business Address_____City_____State_____Zip_____

Spouse or Parent's Name_____Employer_____Work Phone_____

Whom May We Thank For Referring You?_____

Person to Contact in Case of Emergency_____Phone_____

Responsible Party

Name of Person Responsible for this Account_____Relationship to Patient_____

Address_____Home Phone_____

Email_____Cell Phone_____

Driver's License#_____Birthdate_____Financial Institution_____

Employer_____Work Phone_____SSN#_____

Is this Person Currently a Patient in Our Office? Yes___No___

For your convenience, we offer the following methods of payment. Payment in full at each appointment.

Cash___Personal Check____MasterCard___Visa___Amex__Discover___Care Credit___

Insurance Information

Name of Insured_____Relationship to Patient_____

Birthdate_____SSN#_____Date Employed_____

Name of Employer_____Work Phone_____

Insurance Company_____Group#_____Policy/ID#_____

Ins. Company Address_____City_____State_____Zip_____

How Much is Your Deductible?_____How Much Have You Used?_____Max Annual Benefit_____

Do You Have any Additional Insurance? Yes___ No___ If yes, Complete the following:

Name of Insured_____Relationship to Patient_____

Birthdate_____SSN#_____Date Employed_____

Name of Employer_____Work Phone_____

Insurance Company_____Group #_____Policy/ID#_____

Ins. Company Address_____City_____State____Zip_____

OVER

Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

1.Are you under medical treatment now? Yes__No__

2.Have you been hospitalized for any illness In the last 5 years? If yes, explain_____ Yes__No__

3. Are you taking any medications? Please List_____ Yes__No__

4. Have you ever taken Fen-Phen/Redux? Yes__No__

5. Do you use Tobacco? Yes__No__

6. Do you use controlled substances? Yes__No__

7. Are you wearing Contact Lenses Yes__No__

9.Are you **ALLERGIC** to any of the following?

Local anesthetics	Yes__No__
Penicillin or Antibioditics	Yes__No__
Sulfa Drugs	Yes__No__
Barbituates	Yes__No__
Sedatives	Yes__No__
Iodine	Yes__No__
Aspirin	Yes__No__
Any Metals	Yes__No__
Latex	Yes__No__
Other _____	

8.Women Only- **A.)**Are you pregnant or think you might be pregnant? Yes__No__

B.) Are you nursing ? Yes__No__

C.) Are you taking oral contraceptives? Yes__No__

Do you have or have you ever had any of the following?

High Blood Pressure	Yes__No__	Heart Disease	Yes__No__	Chest Pains	Yes__No__
Heart Attack	Yes__No__	Pacemaker	Yes__No__	Easily Winded	Yes__No__
Rheumatic Fever	Yes__No__	Heart Murmur	Yes__No__	Stroke	Yes__No__
Fainting/Seizures	Yes__No__	Angina	Yes__No__	HayFever/Allergies	Yes__No__
Asthma	Yes__No__	Emphysema	Yes__No__	Tuberculosis	Yes__No__
Low Blood Pressure	Yes__No__	Cancer	Yes__No__	Radiation Therapy	Yes__No__
Epilepsy/Convulsions	Yes__No__	Arthritis	Yes__No__	Glaucoma	Yes__No__
Leukemia	Yes__No__	Joint Replacement	Yes__No__	Liver Disease	Yes__No__
Diabetes	Yes__No__	Hepatitis	Yes__No__	Heart Trouble	Yes__No__
Kidney Disease	Yes__No__	STD	Yes__No__	Respiratory Problems	Yes__No__
AIDS/HIV	Yes__No__	Stomach Trouble	Yes__No__	Mitral Valve Prolapse	Yes__No__
Thyroid Problem	Yes__No__	Ulcers	Yes__No__	Other_____	

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

1.Do your gums bleed when brushing/flossing? Yes__No__

2.Are your teeth sensitive to hot or cold? Yes__No__

3.Are your teeth sensitive to sweet? Yes__No__

4.Do you feel pain to any teeth? Yes__No__

5.Do you have any sores/lumps in your mouth? Yes__No__

6.Have you had any head,neck,or jaw injury? Yes__No__

7.Have you had clicking or pain in your jaw? Yes__No__

8.Do you wear dentures/partial dentures Yes__No__

9. Do you like your Smile? Yes__No__

10. Do you have frequent headaches? Yes__No__

11.Do you clench/grind your teeth? Yes__No__

12.Do you bite your lips/cheeks? Yes__No__

13.Have you had difficult extractions in the past? Yes__No__

14.Have you ever had prolonged bleeding following extractions? Yes__No__

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Signature