DENT 1ST DENTAL CARE

www.DentFirst.com

_____
Chart#

DentFirst Buford 678-546-3700
3290 Buford Drive, Buford, GA 30519
DentFirst Cumming 678-947-6077
1175 Buford Rd. Ste. 500, Cumming, GA 30041
DentFirst Duluth 770-476-9000
3502 Satellite Blvd., Duluth, GA 30096
DentFirst Johns Creek 770-476-9595
9775 Medlock Bridge Ste I, Johns Creek, GA 30097-4442
DentFirst Jonesboro 770-961-2000
6568 Tara Blvd., Jonesboro, GA 30236
DentFirst Kennesaw 770-427-6000
440 Barrett Parkway, Suite #29, Kennesaw, GA 30144
DentFirst Lenox 404-325-9000
3435 Lenox Rd NE, Atlanta, GA 30326
DentFirst Lithonia 770-484-4343
7230C Stonecrest Pkwy, Lithonia, GA 30038
DentFirst McDonough 770-898-1550
1391 Highway 20 West, McDonough, GA 30253
DentFirst Norcross 770-448-3030
6060 Dawson Blvd, Norcross, GA 30093
DentFirst Perimeter 770-671-0001
80 Perimeter Center Place, Atlanta, GA 30346
DentFirst Smyrna 770-433-1000
2697 Spring Road, Smyrna, GA 30080

Today's Date _____

PATIENT'S INFORMATION

(please print)

First Name & Middle Initial _____

Last Name _____

Street Address _____

City _____ State _____

Zip Code _____

Check Your Best Contact#
☐ Home Phone # _____
☐ Work Phone # _____
☐ Cell Phone # _____

If we cannot reach you by phone, we may text you unless you opt out by checking this box ☐

SSN# _____

Date of Birth (MM/DD/YYYY) _____ Age _____

Marital Status: Single Married Sex: Male Female

E-Mail Address _____

DentFirst uses your email address to send e-statements, offer online payments and online appointment scheduling.

☐ Check here to receive only mailed paper statements.*

Employer _____

Is the patient the SAME person as the policyholder? (circle Yes or No)
If "Yes", then skip the rest of this box.
If "No", what is the relationship of the patient to the policyholder?
(circle one) Husband Wife Son Daughter Other _____

POLICY HOLDER'S INFORMATION

(please print)

First Name & Middle Initial _____

Last Name _____

Street Address _____

City _____ State _____

Zip Code _____

Check Your Best Contact#
☐ Home Phone # _____
☐ Work Phone # _____
☐ Cell Phone # _____

SSN# _____

Date of Birth (MM/DD/YYYY) _____ Age _____

Marital Status: Single Married Sex: Male Female

E-Mail Address _____

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☐ Check here to receive only mailed paper statements.*

Employer _____

INSURANCE INFORMATION:

Policy Holder's Name _____ Insurance ID# _____

Primary Insurance Company _____ Group # _____

Policy Holder's Name _____ Insurance ID# _____

Secondary Insurance Company _____ Group # _____

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

Name _____ Relationship _____

Address _____ Telephone #( ) _____

Whom may we thank for referring you to our office?

_____Friend or Family Member (Name) _____ Doctor/ER _____

Insurance Company____ Saw Sign ____ DentFirst Website ____ Social Media Website ____ Coupon/Flyer ____ Yellow Pages ____

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 DentFirst,P.C. I acknowledge that all non-current balances on accounts over sixty days will be charged a service fee of 1.75% per month (21% annually) on the unpaid balance 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 attorney fees, will be added to my balance due. *Past Due statements sent via postal mail incur a $5 printing and postage fee. I acknowledge receipt of DentFirst's "Notice of Privacy Practices" attached. I understand that the dentists at DentFirst are independent contractors who have full authority, responsibility and control over their work. They are neither agents nor employees of DentFirst,P.C.

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

PLEASE FLIP THIS SHEET UP AND FILL OUT THE MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. When did you last receive dental treatment? _____
   What type of treatment? _____
2. Previous Dentist _____
   City, State _____
3. Do you have dentures, partial dentures, bridges or crowns?
   If yes, when were they made? _____ Y N
4. Date of last physical examination _____
5. Have you been hospitalized during the past three years? Y N
6. Have you had any serious illnesses in the past three years?
   If so, please explain. _____ Y N
7. Are you under a physician's care? Y N
   If yes, for what condition? _____
8. Have you ever worn braces? Y N
9. Have you ever had gum surgery? Y N
10. Have you ever had any difficulty with any dental work or extractions? Y N
11. Have you ever had any surgical prostheses? Y* N
    (Joint replacements or implants)
12. I prefer tooth-colored fillings rather than silver/amalgam/ mercury fillings on my back teeth. I understand that my insurance company may only pay towards the cheaper fillings and I will be responsible for the difference in fees, if any. Y N
13. I am happy with the color of my teeth Y N

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR

20. Rheumatic Fever Y N
21. Congenital Heart Defect 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) Y N
27. Stroke Y N

RESPIRATORY DISEASE

30. Asthma, Bronchitis or Emphysema Y N
31. Hay Fever or Sinusitis Y N

ENDOCRINE DISORDERS

40. Diabetes Y N
41. (Hyperthyroidism) or (Hypothyroidism)(Circle One) Y N

BLOOD DISORDERS

50. Anemia Y N
51. Do you bleed excessively when cut? Y N

KIDNEY DISEASE

60. Have you had any kidney infections or surgery? Y N

INFECTIOUS DISEASES

70. Hepatitis Y N
71. Venereal Disease (Within the last 10 years) Y N
72. Tuberculosis Y N
73. HIV Positive Y N

MISCELLANEOUS DISEASES AND DISORDERS

80. Frequent Fainting Y N
81. Liver Disease Y N
82. Arthritis Y N
83. Ulcers Y N
84. Glaucoma Y N
85. Radiation Therapy for Cancer Y N
86. Epilepsy Y N
87. Cancer Y N
88. Do you smoke or use any other form of tobacco? Y N

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

90. Antibiotics Y N
91. Blood Thinners Y N
92. Steroids or Cortisone Y N
93. High Blood Pressure Medicine Y N
94. Tranquilizers Y N
95. Aspirin Y N

Please list all of the prescribed medications you are currently taking:

_____
_____
_____

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

100. Local Anesthetics Y N
101. Penicillin Y N
102. Other Antibiotics Y N
103. Codeine Y N
104. Aspirin or Other Pain Medication Y N
105. Latex Y N
106. Barbiturates or Sedatives Y N
107. Other Medicines or Materials? Y N
If yes, please list. _____

Do you have any medical problem not listed above? If yes, please explain. Y N _____

_____

WOMEN ONLY

110. 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 appointment. If you fail to do so we may be required to reschedule your appointment unless we receive a written exemption from a physician.

_____
PATIENT'S SIGNATURE **DATE**
(Parents must sign for their minor children)

PATIENT'S INITIALS FOR UPDATE: **DATE:**
(Parents must sign for their minor children)

_____ _____
_____ _____
_____ _____

_____
DOCTOR'S SIGNATURE **DATE**

_____
Chart#