COWETA DENTISTRY ASSOCIATES

PATIENT INFORMATION

Patient Name _____ (First / Middle / Last)

Birthday _____ ☐ M ☐ F Age _____ Soc. Sec. # _____ Marital Status _____

Address: _____ Are you a full time student? _____ Where? _____

City _____ State _____ Zip Code _____ County _____

Home Phone: _____ Work: _____ Cell: _____

Who can we thank for referring you to our practice? _____

In case of emergency, who should be notified? Name _____

Phone # (s) _____ Relationship to patient _____

PRIMARY INSURANCE

Responsible Party Name: _____ (First / Middle / Last / Name Called)

Employer: _____ Phone: _____

Birthday: _____ Soc. Sec. # _____

Home Phone: _____ Work: _____ Cell: _____

Address (mailing and street if different): _____

City _____ State _____ Zip Code _____ County _____

Relationship to Patient: _____

Insured's Subscriber name and the address if different: _____

Insurance Company: _____

Group Number: _____ Member ID# _____ Phone: _____

Address: _____

SECOND INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber name _____ Relationship to Patient _____

Birthday: _____ Phone: _____ SSN: _____

Address (mailing and street if different): _____

City _____ State _____ Zip Code _____ County _____

Insurance Company: _____

Group Number: _____ Member ID# _____ Phone: _____

Address: _____

Employer: _____ Phone: _____

ADDITIONAL INFORMATION

List Family Members that are currently in our practice: _____

_____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ Phone: _____

Date of last dental care _____ Date of last X-rays _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If, yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✔) if you have or have had any of the following:

- ☐ AIDS
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other _____

It is EXTREMELY IMPORTANT for us to know if you are taking Dilantin, Tranquilizers, Viagra, Phenobarbital, Blood Thinners (including Aspirin), Cortisones, Insulin, Blood Pressure or Heart medications! Please help us to help you. If you have any question as to whether or not to list a medication, please ask.

MEDICATIONS

Are you on any medication for osteoporosis, such as Boniva or Fosamax? ☐Yes ☐No If so, please list _____

List medication you are currently taking:

_____

_____

Pharmacy Name _____ Phone _____ Phone _____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

SIGNATURE

I affirm that the information I have given is correct, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services that I may need. I assign the Doctor all insurance benefits. I understand that Coweta Dentistry Associates files my insurance as a courtesy, but I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I am aware that, in many cases insurance companies reduce the fee of composite (tooth colored) fillings on posterior teeth and that I am responsible for any portion not covered.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18%APR) may be added to my account.

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date _____ Signature _____