Dacula Family Dentistry

Thank you for selecting our team to provide you with the best possible dental care! To help us meet all your dental healthcare needs, 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!

Birth Date:_____ Today's Date:_____

Name:_____

Phone_____ Email_____

PATIENT INFORMATION

Address_____ City_____ State_____ Zip_____ SS#_____

Employer/ If Student, Name Of School _____ Work Phone_____

Business/School Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's name_____Employer_____Work Phone_____

Check the appropriate box: Minor Single Married Divorced Widowed Separated

Whom may we thank for referring you?_____

BILLING INFORMATION

Name of Person Responsible for account_____Birthdate_____Drivers License#_____

Address_____ Phone_____Email_____

Employer_____ Work Phone_____ Relation to Patient_____

Is this Person Currently a Patient in Our Office?_____

For your convenience we offer the following payment methods. Please check the option you prefer. payment due in full at each appointment.

Cash Personal Check Visa MasterCard American Express Discover Care Credit Discuss Office Payment Options

DENTAL INSURANCE INFORMATION

Name Of Insured_____ Relationship to Patient_____ Birth date_____ ID#/ SS#_____

Name of Employer_____ Date Employed_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Ins. Co. Phone_____

Insurance Company Address_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? (IF SO COMPLETE THE FOLLOWING)

Name Of Insured_____ Relationship to Patient_____ Birth date_____ ID#/ SS#_____

Name of Employer_____ Date Employed_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Ins. Co. Phone_____

Insurance Company Address_____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of last exam_____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen Phen/Redux?	☐	☐
5. Have you ever taken Fosomax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	YES	NO
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have ever had reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Kidney Diseases	☐	☐	Cancer	☐	☐	Hay Fever / Allergies
☐	☐	Heart Attack	☐	☐	AIDS or HIV Infection	☐	☐	Arthritis	☐	☐	Tuberculosis
☐	☐	Rheumatic Fever	☐	☐	Thyroid Problem	☐	☐	Joint Replace / Implant	☐	☐	Radiation Therapy
☐	☐	Swollen Ankles	☐	☐	Heart Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Glaucoma
☐	☐	Fainting / Seizures	☐	☐	Cardiac Pacemaker	☐	☐	Sexually Transmitted Disease	☐	☐	Recent Weight Loss
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Stomach Troubles / Ulcers	☐	☐	Liver Disease
☐	☐	Low Blood Pressure	☐	☐	Angina	☐	☐	Chest Pains	☐	☐	Heart Trouble
☐	☐	Epilepsy / Convulsions	☐	☐	Frequently Tired	☐	☐	Easily Winded	☐	☐	Respiratory Problems
☐	☐	Leukemia	☐	☐	Anemia	☐	☐	Stroke	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Emphysema				☐	☐	Other _____

PATIENT DENTAL HISTORY

Previous Dentist_____ Location_____ Date of Last Exam_____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

This office accepts insurance. I understand that I am responsible for the payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary services that I may need during diagnosis and treatment, with my informed consent.

X_____ _____

signature of patient (or parent or guardian) Date