www.DentFirst.com

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DentFirst Cumming 678-947-6077
1175 Buford Rd., Cumming, GA 30041
DentFirst Duluth 770-476-9000
3502 Satellite Blvd. Ste 8, 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 Lithonia 770-484-4343
7230 Stonecrest Pky Ste C, Lithonia, GA 30038

DentFirst Mall of Georgia 678-546-3700
3290 Buford Drive, Buford, GA 30519
DentFirst McDonough 770-898-1550
1391 Highway 20 West, McDonough, GA 30253
DentFirst Norcross 770-448-3030
6060-I McDonough Dr., Norcross, GA 30093
DentFirst Sandy Springs 770-671-0001
1155 Hammond Dr Ste C16, Atlanta, GA 30328
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 ____________

E-Mail Address ____________________

Home Phone # ____________________

Work Phone # ____________________

Soc Sec # ____________________

Cell Phone or Pager # ____________________

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

Marital Status: Single Married

Sex: Male Female

Employer ____________________

Occupation ____________________

Employer Address ____________________

____

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 ____________

E-Mail Address ____________________

Home Phone # ____________________

Work Phone # ____________________

Soc Sec # ____________________

Cell Phone or Pager # ____________________

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

Marital Status: Single Married

Sex: Male Female

Employer ____________________

Occupation ____________________

Employer Address ____________________

____

INSURANCE INFORMATION:

Policy Holder's Name ____________________

Primary Insurance Company ____________________ Policy # ____________

Policy Holder's Name ____________________

Secondary Insurance Company____________________ Policy # ____________

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

Name ____________________ Relationship ____________

Address ____________________ Telephone #( ) ____________

HOW WERE YOU REFERRED TO US?

______ Friend or Family Member (Name) ____________________

Yellow Pages _____ www.DentFirst.com_____ TV or Radio ______ Newspaper ______ Flyer or Coupon ______ Other ___________

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. 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 TURN THIS SHEET OVER 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
    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 or Bronchitis Y N
31. Emphysema Y N
32. 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? Y N
61. Have you had kidney 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. Epilespy Y N
87. Cancer Y N
88. Do you smoke? Y N
89. Do you use any 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 write down 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. Other Pain Medication Y N
105. Aspirin Y N
106. Barbiturates or Sedatives Y N
107. Other Medicines Y N
If yes, what medicines?__________________________

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 will 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)

_________________________ __________
_________________________ __________
_________________________ __________

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DOCTOR'S SIGNATURE **DATE**

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Chart#