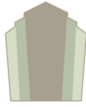

Clayton Dental
AT VILLAGE GROVE

(770)932-0290

4320 Suwanee Dam Road Suite 1800
Suwanee, GA 30024

Patient Information (Confidential)

Name _________________________ M F
First MI Last Sex

Address _________________________City_______

State_____ Zip______Email___________________

SS#____________Birthdate____________Age____

Phone / Home:____________Work:______________

Email Address: ______________________________

Check One: ___Minor ___Single ___Married

___Divorced ___Widowed ___Separated

If college student; ___Fulltime ___Part time

Patient or parent's employer_________________

Business Address _________________________

City_____________State______Zip_________

Spouse or Parent's Name___________________

Employer_____________Wk Phone___________

Emergency Contact______________________

Phone_____________________________

Dental Insurance Information Only

Name of Insured______________________

Relationship to Patient_________________

Birthdate__________SS#______________

Employer Name________________________

Work Phone_________ Cell_______________

Insurance Company_____________________

Phone___________ Group #_____________

Claims Address________________________

City____________ State____ Zip_______

Max. Annual Benefit_______Deductible___

How much have you used this year? ______

Have you met your deductible? ___________

Do you have additional insurance? ________

RESPONSIBLE PARTY

Name of person responsible for this account ____________________Relationship_______

Address______________________________ Home Phone ___________ Cell____________

Is this person currently a patient in our office? ______Yes _______ No

X _________________________________ ____________
Signature of patient or parent if a minor Date

Patient Medical History / Name ____________ Age ___ Date _________

	Yes	No
Are you in good health?	___	___
Have there been any changes in your general health within the past year?	___	___

Date of last physical exam ______________

Physician's Name and Phone Number

____

	Yes	No
Are you under care of physician?	___	___
Have you ever been hospitalized?	___	___

If yes, explain ________________________

	Yes	No
Are taking any medications?	___	___

If yes, please list ______________________

____

	Yes	No
Do you use tobacco?	____	____
Are you allergic to medications or anything else?	____	____

Do you have or have you had any of the following:

	Yes	No
Rheumatic fever	____	____
Heart defect, murmur, MVP	____	____
High / low blood pressure	____	____
Asthma	____	____
Cancer	____	____
Diabetes	____	____
Epilepsy / seizures	____	____
HIV	____	____
Joint replacement	____	____
Kidney / liver disease	____	____
Mental disorders	____	____
Pacemaker	____	____
Pregnancy	____	____

Due Date ________________

	Yes	No
Radiation therapy	____	____
Respiratory problems	____	____
Sinus problems	____	____
Stomach problems	____	____
Stroke	____	____
Tuberculosis	____	____
Tumors	____	____
Thyroid problems	____	____
Ulcers	____	____
Codeine allergy	____	____
Penicillin allergy	____	____

Are you:

Presently being treated for any illness?	Y	N
Aware of a change in your general health?	Y	N
Subject to frequent headaches?	Y	N
Considered a touchy person?	Y	N
Often unhappy or depressed?	Y	N
Easily upset or irritated?	Y	N

Whom may we thank for referring you to our practice? ____ _______________

If not referred by another patient, how did you hear about us? _____ Sign ____Dental office _____ Yellow pages _____ Newspaper _____ Brochure _____ Other

DENTAL HISTORY

Please answer yes or no to the following:

* unhappy with the appearance of your teeth Y N
* unfavorable dental experiences y N
* dental fears Y N
* problems with effectiveness or bad reactions to dental anesthetic Y N
* orthodontic treatment (braces) Y N
  If yes, when:__________________
* periodontal (gum) treatment Y N
  If yes, when:_________________
* bleeding gums Y N
* avoid brushing any part of your mouth Y N
* part of your mouth is sensitive to temperature Y N
* sore teeth Y N
* burning sensation in your mouth Y N
* difficulty swallowing Y N
* an unpleasant taste or odor in your mouth Y N
* dry mouth, throat, or eyes Y N
* jaw problems (temporomandibular joint) Y N
* difficulty opening your mouth widely Y N
* stiff neck muscles Y N
* awaken with awareness of your teeth or jaws Y N
* tension headaches Y N
* clench or grind your teeth Y N
* jaw clicking or popping Y N
* lost any teeth Y N
* do you sweat or tremble during exams Y N
* do strange people or places make you afraid Y N

Date of last dental visit:____________________
Dentist's name:____________________________
Reason for this visit:________________________

Have you ever considered whitening your smile? Y N
Would you like to improve your smile? Y N
If yes, what would you improve? Y N
Do you ever wake up with sore jaws, a sore neck, or a headache? Y N
Are you experiencing any dental discomfort? Y N
If yes, explain ______________________________

Consent for Services

So that you do not have to sign forms and to assist you in filing your insurance, we will keep a "signature on file" form on file and an authorization to release information. This authorizes any provider, insurer or other organization to release any information regarding dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agents to determine benefits payable. Do we have permission to keep your signature on file as explained? ______ Yes ______ No

We take photographs of patients before and after extensive treatment. These pictures allow others to visualize the dramatic effects of dentistry. We will not release any photos without your consent. Do we have your permission to release photos? ____Yes ____No

Every appointment made is reserved exclusively for each patient. We reserve the right to charge a minimum of $50.00 for any appointments cancelled or broken without **48 hours** advance notice. Please acknowledge you understand. ________ I understand the policy.
To the best of my knowledge, all of the information provided is true and correct. If I ever have any change in my health, I will inform doctors at the next appointment without fail. I have read the above conditions of treatment and payment and agree to their consent.

____ ________________
Signature of patient, parent, or guardian Date

Relationship to patient: __________________________________