



BUCKHEAD DENTAL

- ASSOCIATES, P.C. -

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. Please complete both pages of the following "Get Acquainted Questionnaire" so that we may better serve you.

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____
 First Name You Prefer: _____
 Address: _____
 Home Telephone: _____
 Cell Telephone: _____
 Work Telephone: _____
 Employer: _____
 Email Address: _____
 Nearest Relative: _____

SSN: _____
 Date Birth: _____
 Single: Married:
 Divorced: Widowed:

Spouse's Name: _____
 Spouse's D.O.B.: _____
 Spouse's SSN: _____
 Spouse's Employer: _____
 Spouse's Work Tel: _____
 Relative's Tel: _____

When and where is the best time/place to reach you? _____
 Person responsible for payment of account? _____
 Telephone: _____
 Address: _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Do you have dental insurance? Yes: No:

Insurance Co. Name: _____
 Employer: _____
 Group #: _____ Subscriber ID #: _____
 Insurance Address: _____ Telephone: _____

We are happy to assist you in obtaining the maximum benefits specified in your insurance contract. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. You are responsible for all fees for services rendered to you.

I, the patient or guardian, certify that all information is correct and authorize any information to be released regarding medical or dental history, treatment, or credit reference to Buckhead Dental Associates, P.C.

Signature: _____

MEDICAL HISTORY

Physician's Name: _____

Date of Last Physical: _____

1.	Do you consider yourself to be in good health?	Yes	___	No	___	Unsure	___
2.	Are you presently receiving treatment under a physician?	Yes	___	No	___	Unsure	___
3.	Are you taking any medication at this time? If yes, please list:	Yes	___	No	___	Unsure	___
4.	Do you have diabetes?	Yes	___	No	___	Unsure	___
5.	Has anyone in your family had diabetes?	Yes	___	No	___	Unsure	___
6.	Have you ever been told you have high or low blood pressure?	Yes	___	No	___	Unsure	___
7.	Have you ever had any heart ailments?	Yes	___	No	___	Unsure	___
8.	Have you ever had any kidney or bladder problems?	Yes	___	No	___	Unsure	___
9.	Have you ever had any liver problems or hepatitis?	Yes	___	No	___	Unsure	___
10.	Have you ever had a sexually transmitted disease (syphilis, gonorrhea, herpes, etc.)? If yes, when?	Yes	___	No	___	Unsure	___
11.	Have you ever been tested for the HIV Virus?	Yes	___	No	___	Unsure	___
12.	Are you HIV-positive?	Yes	___	No	___	Unsure	___
13.	Do you have AIDS?	Yes	___	No	___	Unsure	___
14.	Have you ever had Rheumatic fever, Rheumatic heart disease, or a heart murmur?	Yes	___	No	___	Unsure	___
15.	Do you require antibiotics before dental treatment?	Yes	___	No	___	Unsure	___
16.	Have you ever had excessive bleeding, anemia, or other blood problems?	Yes	___	No	___	Unsure	___
17.	Have you ever had breathing problems, tuberculosis, asthma or emphysema?	Yes	___	No	___	Unsure	___
18.	Have you ever undergone chemotherapy?	Yes	___	No	___	Unsure	___
19.	Are you pregnant?	Yes	___	No	___	Unsure	___
20.	Are you allergic to any medications or latex? If yes, please list:	Yes	___	No	___	Unsure	___
21.	Do you smoke?	Yes	___	No	___	Unsure	___
22.	Have you had any major surgery? If yes, please list with date:	Yes	___	No	___	Unsure	___
23.	Please list any other condition that you feel we need to know.						
24.	Do you fear dentistry?	Yes	___	No	___		
25.	Are you presently having any problems in connection with your mouth?	Yes	___	No	___		
26.	Are you pleased with the appearance of your teeth?	Yes	___	No	___		
27.	When did you last have a dental treatment? _____	X-Rays?	_____				
28.	Have you ever experienced pain or discomfort in your jaw joint?	Yes	___	No	___		