Dental Associates of Southwest Georgia

718 North Broad Street
Cairo, GA 39828
229-377-4204

Patient Name:_____ Social Security #:_____
Date of Birth:_____ Gender : Male or Female
Marital Status: Married Single Minor Widowed Other

Mailing Address:_____ City_____ State _____ Zip_____
Home Phone_____ Work Phone_____Email:_____
Cell Phone_____ Race: White Black Hispanic Asian Arabic Other
Circle which dentist you would like to see: Dr Leggett Dr Kendrick

Responsible Party (parent or guardian for minors)
Name _____ SS#_____
Date of Birth_____ Relationship to Patient_____

Address_____ City_____ St_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____

Insurance Information
Name of Insurance Co._____ Policy #_____

Name of Insured_____ SS# of Insured_____

Date of Birth of Insured_____ Employer_____
Group #_____ Insurance Co. Phone # _____

Consent and Authorization

The undersigned hereby authorizes the Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.
Privacy Notice Release: I hereby give permission to Dental Associates of Southwest Georgia, the staff and appointees to transmit information, personal data and other identifying characteristics about my health history and dental treatment as they may deem necessary in regards to my treatment.

Responsible Party's Signature _____ **Today's Date**_____

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Medical History

Patient Name:_____ Date of Birth:_____
When was your last dental visit?_____ Who was your Dentist?_____
Who is your medical doctor?_____ Office phone # _____
Your current physical health is (circle one) GOOD FAIR POOR
Are you currently under the care of a physician? YES NO
If YES, please explain:_____Pharmacy name and #_____

Are you taking any prescription or over-the-counter drugs? YES NO
If YES, please list each one:_____

Please circle any illnesses you have or ever had, or currently have now:

Acid Reflux	Epilepsy	Kidney Disease	Seasonal Allergies	High Cholesterol
Anemia	Excessive Bleeding	Liver Disease	Sinus Problems	
Asthma	Fainting	Low Blood Pressure	Stomach Problems	
Arthritis	Fibromyalgia	Mental Disorders	Stroke	
Artificial Joints	Glaucoma	MVP	Thyroid Disease	
Autism	Heart Murmur	Nervous Disorder	Tuberculosis	
Blood Disease	Heart Disease	Pacemaker	Tumors	
Cancer	High Blood Pressure	Radiation Treatment	Ulcers	
Diabetes	HIV	Respiratory Problems	Venereal Disease	
Dizziness	Jaundice	Rheumatic Fever	Hepatitis	
Sickle Cell Anemia				

Do you smoke or use smokeless tobacco? YES NO If so how many or how often per day?_____

Do you consume alcohol? YES NO If so how many per week? _____

Do you have history of illicit drug use? YES NO Date of last use_____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have unexplained weight loss, bloody phlegm, hoarseness, night sweats, fatigue, fever, chest pains, or had a productive cough for more than 3 weeks. YES NO

Have you ever had, or do you currently have Osteoporosis? YES NO
If YES, please list any drugs you have ever taken in the past or are currently taking for Osteoporosis:

_____

Have you received any donor organs, artificial heart valves, or joint implants? YES NO
Have you ever had trouble with prolonged bleeding after surgery? YES NO

Are you allergic to any of the following?

Aspirin Amoxicillin Codeine Clindamycin Erythromycin Penicillin Keflex Sulfa
Sedatives Iodine Any Metals Latex Rubber Tylenol Ibuprofen Local Anesthetics

Other please explain:_____
Is there any other information we should know about your health or about previous dental visits?
_____
FOR WOMEN: Are you pregnant? YES NO Due Date:_____
Are you nursing? YES NO

Doctors Signature:_____

Health Insurance Portability and Accountability Act
(HIPAA)

Patient Name:_____

Patient Date of Birth:_____

I authorize the release of any and all information including the diagnosis, dental records, procedures, treatment plans, and financial records. The information may be released to:

Please list name and relationship to the patient:

_____

_____

_____

_____

_____

_____

____ check here if you don't want to list anyone

Emergency Contact:_____

phone#:_____

relationship to patient:_____

_____ Date:_____

Patient or Guardian Signature