THE ATLANTA DENTAL GROUP PC

Mark Allan Padolsky DDS MAGD FAOS FACMS Jeffrey Stephen Smith DDS

PATIENT REGISTRATION FORM

Welcome to our practice!

Thank you for selecting our dental team. Please fill out this form completely in ink and print clearly. If you have any questions or concerns, please ask for assistance - we will be happy to help.

Date:_________________________

Name:____Soc. Sec.#______________________ Birth date_____/_____/______
Last First Middle
Home address____City____________________State_______Zip___________
Home phone____________________________Work phone_____________________Call at Work or Home?______________
Are you: _______ Minor_______ Single_______Married_______ Divorced________ Widowed________ Separated________
You or your parent's employer____Occupation______________________
Business Address:____City____________________State_______Zip____________
E-mail address:____
Spouse or parent's name______________________________Employer________________________Work Phone_____________
If you are a student, name of school/college_________________________________City__________________State____________
Person to contact in a emergency____Phone________________________

We appreciate patient's referring others to us. Who may we thank for referring you?_______________________________

RESPONSIBLE PARTY

Name of person responsible for this account____ Relationship_________________
Address____Home Phone_________________
City, State, Zip____ Soc. Sec.#__________________
Employer____ Work Phone_________________

What is the **purpose** of today's visit?____

FINANCIAL POLICY

Payment in full is expected at the time services are rendered unless prior arrangements have been made . For your convenience we offer the following payment options. Please check the option you prefer.

_____ Cash _____ Mastercard ______ Visa_______ American Express _______ Discover

Would you be interested in a loan to help with your dental expenses? (Circle one) Yes No

If you have any questions concerning financial arrangements or need special arrangements, please speak with the Financial Manager.

I understand that accounts which are past due will be assessed a monthly interest and billing charge. I realize that failure to keep this account current may result in the Atlanta Dental Group PC being unable to provide additional services except for dental emergencies or where there has been prepayment for additional services. In the case of default on payment, I agree to pay collection costs and reasonable attorneys fees incurred in attempting to collect on this or any future outstanding account balances.

I realize that a broken appointment is a loss to everyone and that by holding my appointment, I am blocking other patients from this time. I understand that I will be charged $25.00 if I do not give 48 hours notice when I am unable to keep my appointment.

Signed____ Date___________________________________

DENTAL HISTORY

Please circle

Do you have any specific dental problems________ Yes No
Do you have dental examinations on a routine basis? Last visit________ Yes No
Do you think you have active decay or gum disease? ________ Yes No
Do you brush and floss on a regular basis? Discuss________ Yes No
Do your gums ever bleed? Discuss ________ Yes No
Do you like your smile? Discuss________ Yes No
Does food catch between your teeth? Any loose teeth? ________Yes No
Do you want to keep your remaining teeth? ________ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?________ Yes No
Have your past experiences in a dental office always been positive?________ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss________ Yes No
Are you interested in orthodontic treatment? Why________ Yes No
Name of previous dentist (optional):________ Yes No
Date of last full mouth x-rays (16 small films or panoramic):________ Yes No

MEDICAL HISTORY

Are you under a physician's care now? Why? Who? ________Phone#________ Yes No
Have you ever been hospitalized or had a major operation? Discuss ________ Yes No
Have you ever had a serious injury to the head or neck? Discuss ________ Yes No
Are you taking any medications, pills or drugs? What? ________ Yes No
Are you on a special diet? Discuss ________ Yes No
Are you allergic to any medications or substances? Please check box below Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex rubber Other________
Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives ______ Yes No

If yes to any of the starred conditions, please call prior to your appointment... Pre-medication may be required.

	Yes No		Yes No		Yes No
Heart Trouble/Disease		Bruise Easily		Emphysema	
Heart Murmur*		Anemia		Tuberculosis	
Irregular Heartbeat		Excessive Bleeding		Cancer	
Angina / Chest Pain		Sickle Cell Disease		X-Ray Treatments (Radiation)	
Heart Attack/ Failure		Hemophilia (Bleeding problem)		Chemotherapy	
Congenital Heart disorder		Leukemia		Stomach/ Intestinal Disease	
Mitral Valve Prolapse*		Recent Blood Transfusion		Ulcers	
Scarlet Fever		Swelling of Limbs		Recent Weight Loss	
Rheumatic Fever*		Lung Disease		Frequent Diarrhea	
Artificial Heart Valve*		Breathing Problem		Diabetes	
Heart Pace Maker*		Shortness of Breath		Excessive Thirst	
Heart Surgery*		Frequent Cough		Hypoglycemia	
High Blood Pressure		Hay Fever		Liver Disease	
Low Blood Pressure		Sinus Trouble		Hepatitis A (infectious)	
Blood Disease		Asthma		Hepatitis B or C	
Yellow Jaundice		Cold Sores		Thyroid Disease	
Kidney Problems		Fever Blisters		Parathyroid disease	
Renal Dialysis		Herpes		Arthritis/ Gout	
Venereal Disease		Stroke		Rheumatism	
AIDS		Convulsions		Pain in Jaw Joints	
HIV Positive		Epilepsy or Seizures		Cortisone Medicine	
Genital Herpes		Fainting or Dizziness		Glaucoma	
Drug Addiction		Nervousness		Tumors or Growths	
Allergies (Medicines)		Psychiatric Care		Alzheimer's Disease	
Allergies (Pollen or Dust)		Hives or Rash			

Have you ever had any other serious illness not checked above? Discuss________ Yes No
Do you wish to talk to the dentist privately about any problem? ________ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X________ Date________
PATIENT SIGNATURE (PARENT OR GUARDIAN)
Reviewed by Doctor________ Date________
Significant Findings ________
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