

# THE ATLANTA DENTAL GROUP PC

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## 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 credit card refunds do not include non-refundable bank fees.

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 \$ 95.00 for a broken appointment and that I can possibly be charged up to the actual fee if I cancel without 48 hours notice.

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	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina / Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/ Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding problem)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/ Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/ Gout	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Pollen or Dust)	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>			

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 \_\_\_\_\_