

Chart#

DentFirst Buford 678-546-3700 3290 Buford Drive Ste A-3, Buford, GA 30519 DentFirst Cumming 678-947-6077 1175 Buford Rd. Ste. 500, Cumming, GA 30041

DentFirst Duluth 770-476-9000 3502 Satellite Blvd. Ste. 8, Duluth, GA 30096 DentFirst Johns Creek 770-476-9595 9775 Medlock Bridge Ste I, Duluth, GA 30097

DentFirst Jonesboro 770-961-2000 6568 Tara Blvd., Jonesboro, GA 30236

DentFirst Kennesaw 770-427-6000 440 Ernest W Barrett Pkwy #29, Kennesaw, GA 30144

DentFirst Lenox 404-325-9000 3435 Lenox Rd NE, Atlanta, GA 30326

DentFirst Lithonia 770-484-4343 7230 Stonecrest Pkwy Ste. C, Lithonia, GA 30038

DentFirst McDonough 770-898-1550 1391 Highway 20 West, McDonough, GA 30253 DentFirst Norcross 770-448-3030 6060 Dawson Blvd Ste. I, Norcross, GA 30093 DentFirst Perimeter 770-671-001 80 Perimeter Center Place, Atlanta, GA 30346 DentFirst Smyrna 770-433-1000

DentFirst Smyrna 770-433-1000 2697 Spring Road, Smyrna, GA 30080 DentFirst West Midtown 404-975-1735 530 17th Street NW Ste 340, Atlanta, GA 30318

Today's Date	Is the patient the SAME person as the policyholder? (circle Yes or No) If "Yes", then skip the rest of this box.
PATIENT'S INFORMATION	If "No", what is the relationship of the patient to the policyholder?
(please print)	(circle one) Husband Wife Son Daughter Other
First Name & Middle Initial	POLICY HOLDER'S INFORMATION (please print)
Last Name	First Name & Middle Initial
Street Address	Last Name
City State	Street Address
Zip Code	City State
Check Home Phone #	Zip Code
Your Best Work Phone #	☐ Home Phone #
Contact# Cell Phone #	Check Your Best Work Phone #
If we cannot reach you by phone, we may text you unless you opt out by checking this box	Contact# Cell Phone #
SSN#	SSN#
Date of Birth (MM/DD/YYYY) Age	Date of Birth (MM/DD/YYYY) Age
Marital Status: Single Married Sex: Male Female	Marital Status: Single Married Sex: Male Female
E-Mail Address	E-Mail Address
DentFirst uses your email address to send e-statements, offer online	DentFirst uses your email address to send e-statements, offer
payments and online appointment scheduling. Check here to receive mailed paper statements. \$5 printing/postage fee	online payments and online appointment scheduling. Check here to receive mailed paper statements. (\$5 Fee Assesed)
Employer	Employer
INSURANCE INFORMATION:	
Primary Dental Insurance Company	-
Policy Holder's Name	
Secondary Dental Insurance Company	
Policy Holder's Name	
Medical Insurance Company	•
Policy Holder's Name	Insurance ID#
IN CASE OF AN EMERGENCY, LIST YOUR NEAREST	DELATIVE OD EDIEND NOT I WING WITH VOIL
Name	
Address	
Whom may we thank for referring you to our office?	
vynom may we mank for referring you to our office;	Doctor/ER/Urgent Care
Friend or Family Member (Name)	Doctor/ER/Orgent Care

acknowledge receipt of DentFirst's "Notice of Privacy Practices" attached. I understand that the dentists at Dentfirst are independent contractors due. Inactive accounts may be assessed an administrative fee. Past Due statements sent via postal mail incur a \$5 printing and postage fee. I

who have full authority, responsibility and control over their work

SIGNATURE OF PERSON RESPONSIBLE FOR THE PAYMENT OF THE ACCOUNT:

	LASE ANSWER THE FULLOWING QUESTI		_	MISCELLANEOUS DISEASES AND DISURDE		
1.	When did you last receive dental treatment?			80. Frequent Fainting	Y	N
_	What type of treatment?			81. Liver Disease	Y	N
2.	Previous Dentist			82. Arthritis	Y	N
	City, State			83. Ulcers	Y	N
3.	Do you have dentures, partial dentures, bridges of			84. Glaucoma	Y	N
_	If yes, when were they made?	. Y	N	85. Radiation Therapy for Cancer	Y	N
4.	Date of last physical examination			86. Epilepsy	Y	N
5.	Have you been hospitalized during the past three	year	s?	87. Cancer	Y	N
		Y	N	88. Do you smoke or use any other form of tobacco	? Y	N
6.	Have you had any serious illnesses in the past the	-	ears?			
	If so, please explain.		N	Are you currently taking any of the following		
7.	Are you under a physician's care?	Y	N	drugs or medications?		
	If yes, for what condition?			90. Antibiotics	Y	N
8.	Have you ever worn braces?	Y	N	91. Blood Thinners	Y	N
9.	Have you ever had gum surgery?	Y	N	92. Steroids or Cortisone	Y	N
10.	Have you ever had any difficulty with any dental	l		93. High Blood Pressure Medicine	Y	N
	work or extractions?	Y	N	94. Tranquilizers	Y	N
11.	Have you ever had any surgical prostheses?	Y*	N	95. Aspirin	Y	N
	(Joint replacements or implants)			Discontinuo di secono di s		
12.	I prefer tooth-colored fillings rather than silver/a	malga	am/	Please list all of the prescribed medications		
	mercury fillings on my back teeth. I understand	that n	ny	you are currently taking:		
	insurance company may only pay towards the ch	eaper	•			
	fillings and I will be responsible for the difference	ce in				—
	fees, if any.	Y	N			
13.	I am happy with the color of my teeth	Y	N	Do you have an ALLERGY or reaction to any of		
14.	Do you snore or been told you snore?	Y	N	the following medications?		
15.	Have you ever been diagnosed with sleep apnea?	Y	N	100. Local Anesthetics	Y	N
	Have you been prescribed the use of a CPAP?	Y	N	101. Penicillin	Ŷ	N
	you have or have you had any of the following	condi	tions	102. Other Antibiotics	Y	N
	liseases?			103. Codeine	Y	N
	RDIOVASCULAR			104. Aspirin or Other Pain Medication	Y	N
	Rheumatic Fever	Y	N	105. Latex	Y	N
	Congenital Heart Defect	Y*	N	106. Barbiturates or Sedatives	Y	
	Angina or Heart Attack	Y	N			N
	Heart Murmurs	Y	N	107. Other Medicines or Materials?	Y	N
	Congestive Heart Failure	Y	N	If yes, please list.		
	Heart Surgery or Pacemaker	Y*	N	Do you have any medical problem not listed	Y	N
	- ·			above? If yes, please explain.		
	(High) or (Low) Blood Pressure (Circle One)	Y	N			
	Stroke	Y	N			
	SPIRATORY DISEASE	3 7	N.T.	110. Are you pregnant?	Y	N
	Asthma, Bronchitis or Emphysema	Y	N	If yes, when are you due?	1	14
	Hay Fever or Sinusitis	Y	N	ii yes, when are you due?		
	DOCRINE DISORDERS			* If you answer 'Y' to any of the starred questions, curren	ıt Ame	rican
	Diabetes	Y	N	Heart Association standards may require that you take an		
41.	(Hyperthyroidism) or (Hypothyroidism)(Circle One	e)Y	N	immediately before each dental appointment. If you fail t		
	OOD DISORDERS			may be required to reschedule your appointment unless v	ve rece	ive a
	Anemia	Y	N	written exemption from a physician.		
	Do you bleed excessively when cut?	Y	N			
	ONEY DISEASE					
	Have you had any kidney infections or surgery?	Y	N			
	ECTIOUS DISEASES			PATIENT'S SIGNATURE	D.	ATE
70.	Hepatitis	Y	N	(Parents must sign for their minor children)		
71.	Venereal Disease (Within the last 10 years)	Y	N			
72.	Tuberculosis	Y	N	PATIENT'S INITIALS FOR UPDATE:	\mathbf{D}_{l}	ATE:
73.	HIV Positive	Y	N	(Parents must sign for their minor children)		
DO	CTOR'S SIGNATURE DA	TE				

Chart#