Welcome to Middle Georgia Center for Cosmetic Dentistry

1295 Russell Parkway Warner Robins, Georgia 31088

Name _____ Date of Birth _____
First Last MI

Married ☐ Divorced ☐ Widowed ☐ Single ☐ Minor ☐ Male ☐ Female ☐

Address _____
Street Apt# City State Zip

Social Security _____ Email _____

Home Phone _____ Work _____ Cell _____

Employer: _____ Occupation _____

Student: Full Time ☐ Part Time ☐

How did you find out about our office ?

Friend or Family ☐ Facebook ☐ Website ☐ Our Sign ☐ Staff Member ☐ Insurance ☐ Other ☐

Insurnace Information

Primary Dental Insurance: _____ Group #:_____

Insurance Co. Phone _____Policy Holder's Name: _____ Policy

Holder's DOB: _____ Policy Holder's SSN#_____

Relationship to Patient: Patient ☐ Husband ☐ Father ☐ Guardian ☐ Wife ☐ Mother ☐

Secondary Dental Insurance: _____ Group #_____

Insurance Co. Phone _____ Policy Holder's Name: _____

Policy Holder's DOB:_____ Policy Holder's SSN#_____

Relationship to patient: Patient ☐ Husband ☐ Father ☐ Guardian ☐ Wife ☐ Mother ☐

Person Responsible for Account

Please check one

Patient ☐ Husband ☐ Father ☐ Guardian ☐ Wife ☐ Mother ☐

Emergency Contact Information

Please check one

Patient ☐ Husband ☐ Father ☐ Guardian ☐ Wife ☐ Mother ☐

Name: _____

Address _____

_____
City State Zip

Telephone:_____
Home Cell

Date of Birth:_____ Employer _____ /_____
Work Phone

Oral Health

Any known dental problems at this time?	☐ Yes	☐ No	_____
Are any of your teeth sensitive to hot, cold, biting, pressure, or sweets?	☐ Yes	☐ No	_____
Do your gums bleed when you brush or floss?	☐ Yes	☐ No	_____
Have you ever been told you have periodontal (gum) disease?	☐ Yes	☐ No	_____
Are there areas in your mouth you avoid chewing on?	☐ Yes	☐ No	_____
Have you had complete set of cavity finding x-rays in the past year?	☐ Yes	☐ No	_____
Do your jaw joints (TMJ) click, pop, or cause pain?	☐ Yes	☐ No	_____
Have you had your wisdom teeth removed?	☐ Yes	☐ No	_____
Are you aware of any nighttime clenching or grinding of your teeth?	☐ Yes	☐ No	_____
Do your teeth show signs of chipping and /or wear?	☐ Yes	☐ No	_____
Are you missing any other teeth?	☐ Yes	☐ No	_____
Do you have a replacement for missing teeth?	☐ Yes	☐ No	_____

Medical Health Information

Are you under a physicians care now? Yes ○ No ○

Physicians Name? _____ *Date Last Seen?* _____

Any Hospitalizations in the last 5 years? Yes ○ No ○

Do you have to take pre-medication antibiotics prior to dental visits? Yes ○ No ○

Are you taking any medications, pills or drugs? Yes ○ No ○ (Please list below)

_____

Are Are you allergic to any medication or substances? Aspirin ○ Penicillin ○ Codeine ○ Latex ○ Sulfa ○
Dental Anesthetics ○ Erythromycin ○ Tetracycline ○ None ○
Other:_____

WOMEN (Please check if applicable) ○ Pregnant (Due Date _____) ○ Nursing

Do you have, or have you ever had, any of the following? (Please mark below):

Aids/HIV Yes ○ No ○	Diabetes Yes ○ No ○	High Cholesterol Yes ○ No ○	Renal Dialysis Yes ○ No ○
Alzheimer's Yes ○ No ○	Drug Abuse Yes ○ No ○	Hypoglycemia Yes ○ No ○	Shingles Yes ○ No ○
Anaphylaxis Yes ○ No ○	Epilepsy / Seizures Yes ○ No ○	Kidney Problems Yes ○ No ○	Sinus Trouble Yes ○ No ○
Anemia Yes ○ No ○	Emphysema Yes ○ No ○	Liver Disease Yes ○ No ○	Stroke Yes ○ No ○
Arthritis/ Gout Yes ○ No ○	Fever Blisters Yes ○ No ○	MVP Yes ○ No ○	Thyroid Yes ○ No ○
Artificial Joint Yes ○ No ○	Heart Murmur Yes ○ No ○	Osteoporosis Yes ○ No ○	Tuberculosis Yes ○ No ○
Asthma Yes ○ No ○	Heart Attack / Failure Yes ○ No ○	Psychiatric Care Yes ○ No ○	Ulcers Yes ○ No ○
Blood Disease Yes ○ No ○	Hepatitis A / B / C Yes ○ No ○	Radiation Therapy Yes ○ No ○	Venereal Disease Yes ○ No ○
Cancer Yes ○ No ○	Herpes Yes ○ No ○	Scarlett Fever Yes ○ No ○	
Chemotherapy Yes ○ No ○	High Blood Pressure Yes ○ No ○	Smokes / Chews Yes ○ No ○	

Do you take blood thinners or daily asprin? **Yes** ○ **No** ○ ***If yes Please list*** _____

Have you ever taken or are you taking medication for osteoporosis or osteopenia (bone loss or weakening) **Yes** ○ **No** ○

If Yes Please List _____

Please list any other serious / pertinent medical conditions that you have ever had:

_____

Do you Snore? *Yes* ○ *No* ○ *If yes how long have you been aware of your snoring ?* _____

Have you ever been told your breathing stops while asleep? **Yes** ○ **No** ○

Do you take medications for: Heart Condition? **Yes** ○ **No** ○

Thyroid Condition? **Yes** ○ **No** ○ Weight Control? **Yes** ○ **No** ○

Acknowledgment and Authority

- 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 medications change, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
I hereby authorize payment directly to the dental office of the group insurance benefit
I have received a copy of the HIPAA Privacy Policy as required by law
I grant the dental office permission to use the email address given above to contact me with respect to my dental care and to confirm my dental appointments.
By providing your phone number, you consent to receive conversational messages from Hayslip Family Dentsitry. Message frequency may vary. On average, you may receive 1-2 messages per month. Message and data rates may apply. To opt out of receiving SMS messages, reply STOP at any time.

X_____ Date _____

Signature Adult Patient ○ Father ○ Mother ○ Guardian ○