Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Social Security #: _____ Birth Date: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Mobile): _____ (Work): _____

Employer : _____ Occupation: _____

☐ E-mail _____

How may we contact you to confirm your appointments?: ☐ Home ☐ Mobile ☐ Work ☐ E-mail

Spouse/Guardian Information (if applicable)

The following is for the patient's: ☐Spouse ☐Mother ☐Father ☐Guardian ☐Other: _____

Name: _____ Birth Date: _____

☐Male ☐Female

Phone: (Home): _____ (Mobile): _____

Referral Information (if applicable)

Who may we thank for referring you to our office?

Name of person or company referring you to our practice: _____

Dental Insurance Information (if applicable)

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID or SSN #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Insurance Plan Phone Number: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID or SSN#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Insurance Plan Phone Number: _____

Consent for Services

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient named on this form and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of dental services provided in the office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. A service charge of 1.5% monthly will be added to all accounts over 90 days.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Type I Diabetes
  * current A1C_____
- ☐ Type II Diabetes
  * current A1C_____
- ☐ Dry mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
  Type:_____
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
  Type:_____
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stents
  Type:_____
- ☐ Stomach Problems
- ☐ Stroke
  Date:_____
- ☐ Tuberculosis
- ☐ Tumors
- Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____
- ☐ _____
- ☐ **NONE**

· Name of Physician: _____ Phone: _____

·**Have you ever been diagnosed with cancer?** ☐ Yes ☐ No
If so, what type?_____

Did you have **chemotherapy**? ☐ Yes ☐ No Date of last treatment:_____
Did you have **radiation**? ☐ Yes ☐ No Date of last treatment:_____

· **Have you had joint replacement surgery?** ☐ Yes ☐ No
If so, which joint?_____ Date of surgery:_____ Surgeon:_____

·**Do you have an artificial heart valve?** ☐ Yes ☐ No
Date of surgery: _____ Surgeon:_____

· **Have you had an organ transplant?** ☐ Yes ☐ No
If so, which organ?_____ Date of surgery:_____ Surgeon:_____

· Are you pregnant? ☐ Yes ☐ No DUE DATE: _____/_____/_____

· Do you use tobacco products? ☐ Yes ☐ No If so, please list:_____

· Are you ALLERGIC to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ **NONE**

- Other:_____

· Are you currently taking any medication? ☐ Yes ☐No If Yes, please list below:

_____

_____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

· Are you currently under the care of your physician for a specific medical condition? ☐ Yes ☐ No
If yes, please explain: _____

· Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Dental Questionnaire

1. How would you rate you smile? (Please circle)

	1	2	3	4	5	6	7	8	9	10	
Unhappy											I wouldn't change a thing!

2. If anything, what would you change about your smile?

_____

3. How important is maintaining a lifelong healthy smile to you?
   - Not important
   - Somewhat important
   - Very important

4. How important is knowledge about your oral health and information on ways to improve?
   - Not interested
   - Somewhat interested
   - Very interested

5. Do you or any family members have a history of periodontal disease?
   - Yes
   - No
   - Unsure

6. Are you concerned about bad breath?
   - Yes
   - No

7. Have you been diagnosed with sleep apnea?
   - Yes
   - No

8. Do you clench or grind your teeth?
   - Yes
   - No

9. Are you interested in information about:
   - Whitening
   - Veneers
   - Implants
   - Other: _____

PATIENT RECORDS ACCESS RELEASE FORM

I, _____, hereby request a copy of my dental records.
Please send them to the following address listed below.

Savannah Dental Aesthetics
Dr. Russell D. Clemmons, DDS, LLC
310 Eisenhower Drive
Building #8
Savannah, Ga 31406
Email: dr.russellclemmons@gmail.com

Please provide your previous dentist's information:

Doctor's Name:_____

Office Phone Number:_____

Office Address:_____

Patient's DOB:_____/_____/_____

Patient (Guardian) Signature:_____