Dental Care Center at Kennestone
John F. Elliott, DDS
K. Leann Yoda, DMD, MSPH
(770) 424-4565

Patient Information

Date___________________

Patient Name____
Last First MI

Preferred Name_______________________________ Male____ Female____

Married____ Single____ Child____ Other____ explain_______________________

Social Security #___________________________ Date of Birth_____________

Address____
Street Apartment #

____
City State Zip Code

Phone Information

Home #___________________________ Cellular #____________________________

Employer Information

Employer__________________________________Occupation___________________

Work #_________________________ Ext #_________

Address____
Street

____
City State Zip Code

Spouse or Parent Information

Name____________________________________ Relationship___________________

Address____
Street Apartment #

____
City State Zip Code

Referral Information

Whom may we thank for referring you to our office?

Name of person or office referring you _______________________________________

Patient____ Dental Office____ Relative____ Co Worker____ Other ________________

Insurance Information

Dental Insurance Primary

Policy Holder Information

Name__________________________________ Is insured a patient? Yes___ No____

Patient's relationship to insured: Self____ Spouse____ Child____ other____

Address____

Street Apartment #

____

City State Zip Code

Insured's Date of Birth________________________ ID#____________________________

Insured's Employer__________________________________ Group#__________________

Employer Address____

Street Suite #

____

City State Zip Code

Insurance Plan Name & Address____

____

____

Phone #____

Dental Insurance Secondary

Policy Holder information

Name__________________________________ Is insured a patient? Yes___ No____

Patient's relationship to insured: Self____ Spouse____ Child____ other____

Address____

Street Apartment #

____

City State Zip Code

Insured's Date of Birth__________________ ID#___________________________________

Insured's Employer__________________________________ Group#__________________

Employer Address____

Street Suite #

____

City State Zip Code

Insurance Plan Name & Address____

____

____

Phone #____

Health History

Medical Information

Have you ever been diagnosed or treated for any of the following?
Please check all that apply:

___AIDS or HIV positive
___Anemia or Blood Disorder
___ Arthritis: type___________
___Artificial Joints/ Valves
___Asthma
___Blood Disease
___Cancer
___Chemo. / Radiation
___Cardiovascular Disease
___Diabetes
___Epilepsy/ Seizures/ Fainting
___Drug/ Alcohol Dependency
___Abnormal Bleeding
___Hay Fever
___Heart Disease
___Heart Murmur
___Hepatitis: type__________
___High/ Low Blood Pressure
___Liver Disease/ Jaundice
___Kidney Disease
___Mitral Valve Prolapse
___Nervous Condition
___Pacemaker
___Prosthetic Devices
___Respiratory Problems
___Rheumatic Fever
___Sinus Problems
___Stomach Problems
___Stroke
___Thyroid Disorder
___Tuberculosis
___Venereal Disease

Are you presently taking any drugs or medications? Yes___ No___
If Yes, List: ____
Any known allergies, please list: ____
Are you pregnant? Yes___ No___ Due Date____
Any surgery in the past 2 years, list: ____
Do you use tobacco products now, or have you used tobacco products previously? Yes______No______
explain ____

Dental History

What is the purpose of your visit?____
What was the date of your last dental visit?____________________________
Who was your previous dentist, address & phone #______________________________________
____
What was the date of your last full mouth set of dental x-rays? ___________________
Have you ever had problems with or treatment for any of the following?
Please check all that apply:

___Periodontal Disease
___Temporal Mandibular Disorder (TMJ)
___Bleeding gums
___Jaw pain or "popping"
___Grind teeth
___Headaches

How would you describe the condition of your teeth & gums? __Good __Fair __Poor
If you pre-medicate before dental appointments, list medication:_____________________________
If you ever had any complications following dental treatment, explain:
____
____
Would you like whiter teeth, or to change something about your smile? Yes____ No ____
Please explain ____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patient for the costs incurred at the time of treatment.

Treatment plans are discussed at every appointment and fee estimates can only be extended six months from the date of the patient's diagnosis.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

____

Signature of patient, parent or guardian

____

Relationship

____

Date