

**THE ATLANTA CENTER FOR LASER DENTISTRY  
PATIENT REGISTRATION**

**PATIENT**

First Name \_\_\_\_\_ Middle I. \_\_\_\_\_ Last Name \_\_\_\_\_

Circle one: Mr. Mrs. Ms. Dr. Other: \_\_\_\_\_ Name by which you prefer to be called \_\_\_\_\_

Patient is: Policy Holder \_\_\_\_, Responsible Party \_\_\_\_, Responsible party is also the policy holder for the patient \_\_

**If you are the responsible party and you are not the patient, please fill out this next section:**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_

**PATIENT INFORMATION**

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Sex:** Male \_\_ Female \_\_ **Marital Status:** Circle One: Single Married Divorced Separated Widowed

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_

E-mail address \_\_\_\_\_ I would like to receive correspondence via e-mail: Yes \_\_ No \_\_

**Please be assured that we will not disclose your e-mail address to anyone!**

**How** did you hear about our office? \_\_\_\_\_

**Whom** may we thank for referring you? \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relation to patient: Self \_\_ Spouse \_\_ Child \_\_ Other \_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_ Address 2 \_\_\_\_\_

City, St, Zip \_\_\_\_\_ City, St., Zip \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relation to patient: Self \_\_ Spouse \_\_ Child \_\_ Other \_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Address 1 \_\_\_\_\_ Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_ Address 2 \_\_\_\_\_

City, St, Zip \_\_\_\_\_ City, St., Zip \_\_\_\_\_

I, the undersigned, have insurance with \_\_\_\_\_ and assign directly to The Atlanta Center for Laser Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that my insurance contract is between me and my insurance company and that I am financially responsible for all charges, whether or not paid by my insurance. I also understand you will provide me with a "best guess" as to what my insurance company will pay, and that it is not a guarantee of actual payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature \_\_\_\_\_

THE ATLANTA CENTER FOR LASER DENTISTRY  
MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

If you are completing this form for another person, what is your name and relationship to that person?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**It is important that we know health problems you have and medications you are taking so that we may provide you the best possible dental care. Please answer the following questions.**

\_\_\_ Yes \_\_\_ No Are you now under the care of a physician?

**If yes, please indicate the reason.** \_\_\_\_\_

Name of physician \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Have you ever been hospitalized or had a major operation? When? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Do you have active tuberculosis?

\_\_\_ Yes \_\_\_ No Do you have a cough that produces blood?

\_\_\_ Yes \_\_\_ No Have you had an orthopedic joint replacement? When? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Do you have any condition requiring premedication with antibiotics before treatment? \_\_\_\_\_

What condition? \_\_\_\_\_

WOMEN: Are you or could you be pregnant? \_\_\_ Yes \_\_\_ No \_\_\_ Don't know. Nursing? \_\_\_ Yes \_\_\_ No.

**DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

**Yes No ?**

\_\_\_ \_\_\_ Abnormal bleeding

\_\_\_ \_\_\_ AIDS or HIV infection

\_\_\_ \_\_\_ Anemia

\_\_\_ \_\_\_ Arthritis

\_\_\_ \_\_\_ Rheumatoid arthritis

\_\_\_ \_\_\_ Asthma

\_\_\_ \_\_\_ Respiratory problems, **specify:** \_\_\_\_\_

\_\_\_ \_\_\_ Cancer

\_\_\_ \_\_\_ Chemotherapy or Radiation therapy

\_\_\_ \_\_\_ Cardiovascular disease; **if yes, specify:** \_\_\_\_\_

\_\_\_ \_\_\_ Heart Attack or heart trouble; **specify:** \_\_\_\_\_

\_\_\_ \_\_\_ Blood pressure: High or Low **Circle One**

\_\_\_ \_\_\_ Pacemaker

\_\_\_ \_\_\_ Stroke

\_\_\_ \_\_\_ Mitral valve prolapse or heart murmur

\_\_\_ \_\_\_ Chest pain upon exertion

\_\_\_ \_\_\_ Diabetes

\_\_\_ \_\_\_ **Type I** (insulin dependent) or \_\_\_ **Type II**

\_\_\_ \_\_\_ Thyroid Problems: Hyper or Hypo **Circle One**

\_\_\_ \_\_\_ Hemophilia

\_\_\_ \_\_\_ Dry mouth

\_\_\_ \_\_\_ Hepatitis, jaundice, or liver disease

\_\_\_ \_\_\_ Recurrent infections, **if yes, specify:** \_\_\_\_\_

**Yes No ?**

\_\_\_ \_\_\_ Kidney problems

\_\_\_ \_\_\_ Mental disorders; **if yes, specify:** \_\_\_\_\_

\_\_\_ \_\_\_ Night sweats

\_\_\_ \_\_\_ Neurological or psychological disorders;

**specify:** \_\_\_\_\_

\_\_\_ \_\_\_ Persistent swollen glands in neck

\_\_\_ \_\_\_ Severe headaches/migraines

\_\_\_ \_\_\_ Sexually transmitted disease

\_\_\_ \_\_\_ Swelling of any of the limbs

\_\_\_ \_\_\_ G. E. reflux or persistent heartburn

\_\_\_ \_\_\_ Eating disorder; **if yes, specify:** \_\_\_\_\_

\_\_\_ \_\_\_ Gastrointestinal disease

\_\_\_ \_\_\_ Fainting spells or seizures

\_\_\_ \_\_\_ Venereal disease

\_\_\_ \_\_\_ Systemic lupus erythematosus

\_\_\_ \_\_\_ Rheumatic Fever

\_\_\_ \_\_\_ Pain in the jaw joints TMJ/TMD

\_\_\_ \_\_\_ Shingles

\_\_\_ \_\_\_ Ulcers

\_\_\_ \_\_\_ Blood Transfusion

\_\_\_ \_\_\_ Epilepsy

\_\_\_ \_\_\_ Scarlet fever

\_\_\_ \_\_\_ Do you wear a removable full or partial denture?

Do you have any disease, condition, or problem not listed above that you think we should know about? \_\_\_\_\_

Please explain: \_\_\_\_\_

On a scale of one to ten, what is your level of dental anxiety? \_\_\_\_\_

What do you fear the most about dental treatment? \_\_\_\_\_

Approximately when was your last dental exam and cleaning? \_\_\_\_\_

Should we request x-rays from your former dentist? \_\_\_ Please provide his/her name and phone number:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**ARE YOU ALLERGIC, OR HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?**

Yes No ?

- Local anesthetics: novocaine, xylocaine, etc.
- Aspirin
- Ibuprofen
- Penicillin
- Erythromycin
- Any other antibiotics; **if yes, specify:** \_\_\_\_\_
- Barbiturates, sedatives, or sleeping pills; **if yes, specify:** \_\_\_\_\_
- Sulfa drugs
- Codeine, or other narcotics; **if yes, specify:** \_\_\_\_\_
- Latex
- Iodine
- Pollens, or do you have seasonal hay fever
- Foods; **if yes, specify:** \_\_\_\_\_
- Metals; **if yes, specify:** \_\_\_\_\_
- Any other substance; **if yes, specify:** \_\_\_\_\_

If you answered yes to any allergy questions, please specify the type of reaction you had:

\_\_\_\_\_

Yes  No Are you taking, or have you recently taken any prescription or non-prescription medicine(s)?

If yes, what medicine(s) are you taking, or have you recently taken? **List Them Below**

Please include the dosage and frequency of each.

Prescribed drugs: \_\_\_\_\_

Over the counter drugs: \_\_\_\_\_

Yes  No Are you taking any vitamins, natural or herbal preparations and/or food supplements?

**If yes, please list:** \_\_\_\_\_

Yes  No Are you taking, or have you recently taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fenfluramine-phentermine combination)?

Yes  No Do you drink alcoholic beverages? If yes, how much did you drink within the last 24 hours?

\_\_\_\_\_

Yes  No Are you alcohol or drug dependent? If yes, have you received treatment?  Yes  No

Yes  No Do you use drugs or other substances for recreational purposes? If yes, please list:

\_\_\_\_\_

Yes  No Do you use tobacco (smoking, chewing, or snuff)? If yes, how interested are you in stopping?

\_\_\_\_\_ Very interested \_\_\_\_\_ Somewhat interested \_\_\_\_\_ Not interested

Yes  No Do your gums bleed when you brush or floss?

Yes  No Have you ever had periodontal (gum) treatment?

Yes  No Are your teeth sensitive to hot, cold, sweets or pressure?

Yes  No Have you ever had orthodontic treatment (braces)?

Yes  No Do you wear a removable dental appliance (night or athletic guard)?

Yes  No Have you had a serious/difficult problem associated with any previous dental treatment?

**Please explain:**

\_\_\_\_\_

We would like to know the main purpose for your visit today, and please share with us your expectations:

\_\_\_\_\_

\_\_\_\_\_

**I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.**

**Signature of patient/legalguardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Dentist** \_\_\_\_\_ **Date:** \_\_\_\_\_