Lanier Dental Group

819 Thompson Bridge Road
Gainesville, Georgia 30501

Phone: 770-535-8900
Fax: 770-535-8108
www.lanierdental.com

Patient Information and Medical History

Patient Information

Name ______________________

Address ______________________

City/State/Zip ______________________

E-mail Address ______________________

Home Phone __________ Cell Phone __________

Work Phone __________ Birthdate __________

Marital Status __________ Sex __________

Place of Employment ______________________

Employment Address ______________________

City/State/Zip ______________________

Dental Insurance Information

Do You have Dental Insurance? ◯ Yes ◯ No

Are You a Disabled Veteran? ◯ Yes ◯ No

Name of Insured ______________________

Relationship __________ Birthdate __________

Insurance Company ______________________

SS Number ______________________

Group Number __________ Policy Number __________

Ins. Co. Address ______________________

City/State/Zip ______________________

Ins. Co. Phone __________ Member ID # __________

Responsible Party

Name ______________________

Relationship __________ Address ______________________

Employer ______________________

Home Phone __________ Work Phone __________

Emergency Contact

Name ______________________ Phone __________

Dental History

◯ Tooth Pain ◯ Loose Teeth ◯ Gum Disease ◯ Bleeding Gums ◯ Smoke ◯ Snoring/Apnea

◯ Broken Teeth ◯ Jaw/Face Pain ◯ Biting Pain ◯ Hot/Cold Pain ◯ Chew Tobacco ◯ Bad Breath

Would You like Whiter Teeth? ◯ Yes ◯ NO

Payment is due when services are rendered. I understand that I am responsible for professional fees incurred on my behalf regardless of my insurance status. I understand that I am responsible for all costs incurred by Lanier Dental Group, Inc. In the event my account is turned over to an outside agency for collections. Accounts over 30 days past due will be charged interest at the rate of 1.5% monthly on your account balance. I authorize Lanier Dental Group to E-mail appointment reminders, post operative instructions and treatment plan presentations to the address given above. I certify that I have read and understand both sides of this form and that my responses are true and correct.

Patient Signature ______________________ Date __________

Parent or Guardian if Patient is a Minor

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Patient Medical History and Patient Information

Name: ______________________ **Age** ________ **Date** ________

Are You in Good Health? Yes ◯ No ◯

Are you under the care of a Physician? Yes ◯ No ◯

Date of Last Cleaning ______________________

Physician Name ______________________

Address ______________________

Phone ______________________

List ALL Medications you are currently taking
(Including non-prescription and Herbal)

1 ______________________
2 ______________________
3 ______________________
4 ______________________
5 ______________________

For Women Only

Are You Nursing? ◯ Yes ◯ No

Are You Pregnant? ◯ Yes ◯ No

Due Date ____________

Reason for Today's Visit ______________________

Conditions			Conditions			Conditions		
Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Frequent Headaches	☐	☐	Sickle Cell Disease
☐	☐	Alcohol Abuse	☐	☐	Glaucoma	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	HIV+ or AIDS	☐	☐	Stroke
☐	☐	Angina Pectoris	☐	☐	Heart Attack	☐	☐	Thyroid Problems
☐	☐	Arthritis	☐	☐	Hepatitis A, B C Other	☐	☐	Tuberculosis
☐	☐	Artificial Heart Valve	☐	☐	Hemophelia	☐	☐	Ulcers
☐	☐	Artificial Joints	☐	☐	High Blood Pressure			
☐	☐	Asthma	☐	☐	Kidney Problems			
☐	☐	Bisphosphonate Therapy	☐	☐	Liver Disease			
☐	☐	Bleeding Gums	☐	☐	Low Blood Pressure			
☐	☐	Bruise or Bleed Easily	☐	☐	Mitral Valve Prolapse			
☐	☐	Cancer	☐	☐	Pacemaker			
☐	☐	Colitis	☐	☐	Pain in Jaw Joint			
☐	☐	Congenital Heart Defect	☐	☐	Psychiatric Problems			
☐	☐	Diabetes	☐	☐	Radiation Therapy			
☐	☐	Breathing Difficulty	☐	☐	Reaction to Anesthetic			
☐	☐	Do You Snore	☐	☐	Rheumatic Fever			
☐	☐	Drug Abuse	☐	☐	Seisures			
☐	☐	Emphysema	☐	☐	Sexually Transmitted Disease			
☐	☐	Fainting Spells	☐	☐	Shingles			

Allergies

☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other

List ______________________