For Office Use:

Account # _____

1._____

2._____

3._____



Southern Smiles Dental Associates, LLC

Larry L. Webb, D.M.D.

770-968-1720

WELCOME

Thank You for selecting our dental healthcare team! To help us meet all your dental needs, please fill out this form completely.

PATIENT'S FULL NAME _____ **NAME CALLED** _____

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Minor (Child) (Please Check One) Email _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Marital Status: S M D W

Address _____ Home Phone (____) _____

City _____ State _____ Zip _____ Cell Phone (____) _____

SPOUSE'S NAME _____ Phone (____) _____

Other Emergency Contact _____ Phone (____) _____

How did you hear about our office? ❑ Person-_____ ❑ Other-_____

PATIENT'S EMPLOYER _____ Work Phone (____) _____

PERSON RESPONSIBLE FOR PAYMENT: (If different from Patient)
NOTICE - By state law, the parent who brings a child to our office is the responsible party.

Name _____ Email _____

Relationship to Patient _____ Social Security # ____ - ____ - ____ Marital Status: S M D W

Address _____ Date of Birth ____/____/____

City _____ State _____ Zip _____ Phone (____) _____

Employer _____ Phone (____) _____

Employer Address _____

City _____ State _____ Zip _____

PRIMARY DENTAL INSURANCE COMPANY: _____ Group # _____

Claims Address _____ Ins. Phone (____) _____

City _____ State _____ Zip _____

Employee _____ Date Of Birth ____/____/____ ID# _____

Social Security # _____ - _____ - _____ Relationship to Patient _____

SECONDARY DENTAL INSURANCE COMPANY: _____ Group # _____

Claims Address _____ Ins. Phone (____) _____

City _____ State _____ Zip _____

Employee _____ Date Of Birth ____/____/____ ID# _____

Social Security # _____ - _____ - _____ Relationship to Patient _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM ⇨

PATIENT'S Full Name _____ Name Called _____

PRIMARY Physician _____ Phone (_____) _____

Specialist _____ Phone (_____) _____

Other _____ Phone (_____) _____

FOR OFFICE USE

Do you presently have OR have you ever had any of the following: PLEASE READ CAREFULLY

Please check one:	Yes	No	Please check one:	Yes	No
Hospitalization (last 12 months)	❑	❑	Hearing Impaired	❑	❑
Heart Murmur/Rheumatic Fever	❑	❑	Lung Condition/COPD/CPAP/Other	❑	❑
Heart Attack/Stents/Heart Condition	❑	❑	Asthma	❑	❑
Irregular Heart Beat	❑	❑	Sinus Condition	❑	❑
Heart Pacemaker/Defibrillator	❑	❑	Tuberculosis	❑	❑
Damaged or Prosthetic Heart Valves	❑	❑	Do you use tobacco? Type _____	❑	❑
Stroke	❑	❑	Hepatitis or Jaundice Type _____	❑	❑
High Blood Pressure	❑	❑	AIDS/ARC/HIV	❑	❑
Low Blood Pressure	❑	❑	Venereal Disease/STD	❑	❑
Chest Pain	❑	❑	Liver Condition	❑	❑
Anemia or Blood Disorder	❑	❑	Kidney Condition	❑	❑
Abnormal Bleeding/Clotting/Healing	❑	❑	Diabetes	❑	❑
Blood Transfusion	❑	❑	Hyperglycemia/Hypoglycemia	❑	❑
Anxiety/Depression/Psychiatric/Other	❑	❑	Thyroid Condition	❑	❑
Alzheimer's Disease/Dementia/Memory	❑	❑	Cancer Type _____	❑	❑
Drug or Alcohol Addiction	❑	❑	Radiation Treatment	❑	❑
Convulsions/Fainting/Seizures	❑	❑	Arthritis/Rheumatoid/Auto Immune	❑	❑
Head/Neck/Jaw Injury	❑	❑	Joint Replacement/Prosthesis	❑	❑
Glaucoma/Blindness	❑	❑	Stomach Ulcers/GI Condition/Reflux	❑	❑
Cold Sores/Fever Blisters/RAU	❑	❑	Osteoporosis/Bisphosphonate	❑	❑

REACTION or ALLERGY TO:

Please check one:	Yes	No		Yes	No
Codeine	❑	❑	Latex	❑	❑
Penicillin	❑	❑	Bleach	❑	❑
Novocaine/Anesthetic	❑	❑	Iodine	❑	❑

WOMEN: Are you currently

	Yes	No
On Birth Control	❑	❑
Pregnant-Due Date _____	❑	❑
Breast Feeding	❑	❑

❑ ❑ Other(please list) _____

Please list all medical or dental information which may affect your treatment: _____

Please List All Medications You Are Taking:

Medication	For Office use:	Medication	For office use:

- The above information is accurate to the best of my knowledge.
- I understand that all fees are to be paid at time of service, unless prior arrangements have been made.
- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such dental care to third party payors and/or other health practitioners.
- I authorize the Insurance Company to pay Southern Smiles Dental Associates, LLC, directly for any benefits due to me for the treatment rendered.
- I permit a copy of these authorizations to be used in place of the originals.
- I understand that professional services are rendered and charged to the patient; therefore, I am responsible for my account, NOT the Insurance Company.
- In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to affect collection of this account or future outstanding accounts.

Signature of Patient, Parent, and/or Responsible Party Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM ⇨