

GEORGIA PERIODONTICS, P.C.

L. HILL GRIFFIN, D.D.S.

MICHAEL B. HAGEARTY, D.D.S.

MARK T. LITTERER, D.M.D.

AUBREY H. SCHER, D.M.D.

Date: _____

PERSONAL INFORMATION

Mr./Mrs./Ms.: _____
(first) (middle) (last)

If Child, Parent's Name: _____
(first) (middle) (last)

Spouse's Name: _____
(first) (middle) (last)

Residence: _____
(street) (city) (state) (zip)

Home Phone: (_____) _____ Work Phone: (_____) _____ Ext. _____

CellPhone: (_____) _____

Social Security #: _____ - _____ - _____ Spouse's Social Security #: _____ - _____ - _____

Marital Status: Married Single Divorced Separated Widowed

Employment States: Full-time Part-time Retired Not Employed

Birth Date: ____/____/____

Referred by: _____

General Dentist: _____

Billing Address: _____
(street) (city) (state) (zip)

Nearest Relative (not living with you): _____
(name) (relationship)

Address: _____
(street)

(city) (state) (zip) (home phone) (work Phone)

DENTAL AND MEDICAL HISTORY

Age _____

Who referred you to our office? Mr., Mrs., Ms. or Dr. _____

Present Dentist: _____ How Long? _____

**PLEASE CHECK THE BOX TO THE LEFT WITH A (✓) IF THE ANSWER IS YES.
PLEASE LEAVE THE BOX BLANK ☐ IF THE ANSWER IS NO. Fill in line if necessary.**

1. ☐ Are you experiencing pain or discomfort from your mouth at this time? Lately? _____
2. ☐ Are your teeth sensitive to heat, cold, or sweets? Which? _____
3. ☐ Have you noticed swollen areas of the gums? _____
4. ☐ Do your gums bleed when you brush or floss your teeth?
5. ☐ Have you noticed any loose teeth? _____
6. ☐ Have you noticed any bad odors or tastes in your mouth? _____
7. ☐ Are you aware of clenching, grinding, or gritting your teeth together in the day or at night in your sleep?
When? _____
8. ☐ Do you smoke? How much? _____
9. ☐ Have you been under more nervous tension or stress than average lately?
10. ☐ Would you be tremendously disturbed if you had to lose all your teeth and wear dentures?
11. ☐ Have you had previous periodontal (gum) treatment? When and by Whom? _____
12. How many times do you have your teeth cleaned each year? _____ Last cleaning? _____
13. How often do you brush teeth? _____
14. List other oral hygiene aids used regularly: _____
15. ☐ Do you consider your medical health to be good? Date of last physical exam: _____
16. Circle any of the following medical conditions which you have had or have at present:

High Blood Pressure	Mitral Valve Prolapse	Kidney Disease	Arthritis
Heart Disease	Heart Valve or Joint Replacement	Liver Disease	Blood Clotting Problems
Rheumatic Fever	Diabetes	Hepatitis	Glaucoma
Heart Murmur	Lung Disease	Ulcers	AIDS-HIV Positive
17. ☐ Do you have any disease, condition, or problems not listed?

18. ☐ Has your physician advised you to take antibiotics before dental treatment?

INSURANCE INFORMATION

Primary Dental Insurance: Yes No

Secondary Dental Insurance: Yes No

Insurance Group #: _____

Insurance Group #: _____

Employee ID or SS#: _____

Employee ID or SS#: _____

Name of Insurance Company:

Name of Insurance Company:

(Address)

(Address)

(City/State/Zip)

(City/State/Zip)

(Phone Number)

(Phone Number)

DO YOU HAVE MEDICAL INSURANCE COVERAGE IN ADDITION TO YOUR DENTAL?

Group#: _____ Employee ID #: _____

Insurance Claim Signature: _____ **Date:** _____

I hereby authorize payment of group dental benefits, otherwise payable to me, to the named provider for professional services rendered.

EMPLOYMENT INFORMATION

Patient's Employer: _____ Phone#: _____

Employer's Address: _____
(street) (city) (state) (zip)

Present Position: _____ How Long? _____

Spouse's Employer: _____ Phone #: _____

Employer's Address: _____
(street) (city) (state) (zip)

Present Position: _____ How Long? _____