TALBOT DENTAL ASSOCIATES, P.C.

78 River Terrace • Ellijay, Georgia 30540

Patient Information

Date ____________________

Name ______________________________ Social Security # ____________________

Address ______________________________ Home Phone ____________________

____________________ Zip __________ Date of Birth ____________________

Employed By ______________________________ Bus. Phone ____________________

Address ______________________________ Spouse ____________________

Email Address ____

If patient is a full time college student, college name ______________________________

How did you hear about our office? ______________________________

In case of emergency who should be notified? ____________________ Phone __________

❑ Single ❑ Married ❑ Separated ❑ Divorced

Medical / Dental

Is your general health good? ❑ yes ❑ no Are you under a physician's care? ❑ yes ❑ no

Name of your physician ______________________________

Name of your previous dentist ______________________________

Do you have any or have you had any of the following? If yes, please check the box.

❑ Heart Trouble	❑ Tuberculosis	❑ Bleeding Problems	❑ Tumors
❑ Heart Murmur	❑ Epilepsy	❑ High Blood Pressure	❑ Hepatitis
❑ Allergies	❑ STD	❑ Arthritis	❑ Asthma
❑ HIV / AIDS	❑ Diabetes	❑ Stomach Ulcers	❑ Cold Sores
❑ Breathing Trouble	❑ Joint Replacement	❑ Mouth Ulcers	

Are you now taking any drugs or medications? ❑ yes ❑ no

If so, list ______________________________

Are you allergic or have you reacted adversely to any of the following? If yes, please check box.

❑ Local anesthetic ❑ Penicillin ❑ Aspirin ❑ Sulfa ❑ Other...List ____________________

Are you subject to fainting spells of seizures? ____________________

Women, are you pregnant? ❑ yes ❑ no Are you taking birth control pills? ❑ yes ❑ no

Have you noticed any of the following problems? If yes, please check box.

❑ Pain when chewing? ❑ Bleeding gums? ❑ Bad breath?

Are teeth sensitive to hot, cold or sweets? ❑ yes ❑ no

Do you have any disease, condition or problem not listed in Medical / Dental History that you think I should know about? ❑ yes ❑ no

If so, please explain ______________________________

Person responsible for account ______________________________

Relation to patient ______________ Birthdate ______________ SS# ______________

Address ______________________________ Phone ______________

City ______________ State ______________ Zip ______________

Employed By ______________________________ Bus. Phone ______________

Bus. Address ______________________________

Please sign ______________________________ Date ______________

Primary Insurance

Insurance Company ______________________________

Insurance Company Address ______________________________

City ______________ State ______________ Zip ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan:

____

____

____

Is patient covered by additional insurance? ❑ yes ❑ no

If yes: Subscriber name ______________________________

Relation to patient ______________ Birthdate ______________

Address ______________________________ Phone ______________

City ______________ State ______________ Zip ______________

Employed By ______________________________ Bus. Phone ______________

Insurance Company ______________________________

Insurance Address ______________________________

SS# ______________ Group # ______________ Subscriber # ______________

❑ Check here if you have Medicaid. Policy number

Please make sure we have a copy of your insurance or medicaid on file.

Assignment and Release

I, the undersigner certify that I (or my dependent) have insurance coverage with ______________ ______________________________ Insurance Company(ies) and assign to Dr.______________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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 insurance submissions.

______________________________ ______________ ______________

Responsible Party Signature | Relationship | Date