

(229)377-6588

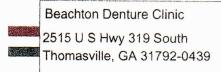
## **Medical & Dental History Form**

				Chart #.	
				<u> </u>	FOR OFFICE USE ONLY
Patient Na	ame:				
	Last		First	MI	Preferred Name
Title:	Gender:	) Male 🔘 Female	Family Status: U	Married 🔾 Sing	gle 🔾 Child 🔾 Other
Birth Date	:	Prev. Visit:	Email Addr	ress:	
Phone:				Best time	to call:
	Home	Work Ext	Mobile		
Address:				κ.	
	City			State	Zip Code
Social Se	ecurity No.				
				*	
How did y	you first learn about ou	r practice?			
* Magaz	ine Ne	wspaper	Radio	Sign	
Television YellowPages Friend/Relative Internet/Website					
Other Doctor Outside Agency					
Name of person referring you to our practice:					
What is the reason for today's visit?					
			-		
Have you received treatment in our office previously? If so when?					

## Beachton Denture Clinic 2515 U S Hwy 319 South Thomasville, GA 31792-0439

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Are you currently wearing dentures? If yes, when did you receive your last dentures?					
Do you use denture adhesives, pastes or powder? If so describe					
○ Yes ○ No					
Are you in pain or do you have sores in your mouth?					
○ Yes ○ No					
Your Primary Care Physician's name, address, & phone number:					
What is the date (or approximate date) of your last medical exam?					
Please list all medications you are currently taking:					
Are you allergic to Latex?					
Yes No					
Have you ever taken the drug Fen Phen or Redux?					
Yes No					
Do you smoke cigarettes or use tobacco products?					
○ Yes ○ No					
Do you use illegal drugs? ( i.e.marijuana, or cocaine)					
○ Yes ○ No					
Are you pregnant, taking birth control? Circle one					



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## Do you have or ever had:

teeth EXTRACTED? If so, when?								
Bleeding problems?								
a bad reaction to ANEST	HESIA) (like Novacaine)							
Yes No	incomity (into recountry)							
*Pre-Med - Amox	*Pre-Med - Clind	*Pre-Med - Other	AIDS-HIV					
Allergy - Aspirin Allergy - Codeir		Allergy - Erythro	Allergy - Latex					
Allergy - Other	Allergy - Penicillin	Allergy - Sulfa	Anemia					
Arthritis	Artificial Joints	ASPIRIN	Asthma					
Blood Disease	BLOOD THINNERS	Cancer	Chemical					
Chemotherapy	Circulatory Problems	Cortisone Treatment	Cough, Blood produci					
Cough, persistant	Demoral	Diabetes	Epilepsy					
Fainting	Foot Swelling	Glaucoma	Heart Disease					
Heart Murmur	Hemophilia	- Hepatitis	High Blood Pressure					
HIV	Kidney Disease	Liver Disease	Mitral Valve Prolaps					
Multiple Myeloma Nervous Disorders		Osteoporosis	Pacemaker					
Percocet	Pregnancy	Radiation Treatment	Respiratory Problems					
Rheumatic Fever Rheumatism		Scarlet Fever	Shortness of Breath					
Sinus Problems Stomach Problems		Stroke	Thyroid Problems					
Tuberculosis	Tumors	Tyelonal	Ulcers					
Venereal Disease								
a STROKE? If so when?								

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To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detail appointment without fail.				
Authorization				
I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.				
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.				
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.				
I understand that I am financially responsible for all services provided. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).				
Signature of patient, parent, or guardian:				
Signature:	Date:			
Relationship to Patient:				
**We gladly accept payment by Cash, Check, Master Card, VISA, and Discover. We also offer financing through Care Credit and Lending Club ( for those who qualify).				
	Response Date:			

## HIPAA OMNIBUS RULE <u>PATIENT ACKNOWLEDGEMENT</u> ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES for PHARMACY

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

X	Date:	o processo you. mouranes ciamie.			
	The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this pharmacy,  A copy of this signed, dated Acknowledgement shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTOR / TREATMENT FACILITY IN THE FUTURE.				
*	Please print your name	Please <u>sign</u> your name			
	Legal Representative	Description of Authority			
	Your comments regarding Acknowledgements or Cor	isents:			
	HOW DO YOU WANT TO BE ADDRESSED WHEN SU First Name Only Proper Sir Name				
PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORM (This includes and any care takers, step parents, grandparents who can have access to this patient's recorn Name: Relationship:					
	Name:	Relationship:			