



Welcome to Satilla Family Dentistry - Tell Us About Yourself

Name: \_\_\_\_\_  
Last First MI Title

Preferred Name: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Domestic Partner

How did you hear about Satilla Family Dentistry? \_\_\_\_\_

Do you prefer to be contacted for appointment confirmation via e-mail or phone? \_\_\_\_\_ (Please circle preference)

**Insurance - Primary**

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber SSN/ID: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Name: \_\_\_\_\_

**Insurance - Secondary**

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber SSN/ID: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Name: \_\_\_\_\_

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly Satilla Family Dentistry 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, including any finance charge of 18.5 % and recovery charges. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorized the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent:** I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: \_\_\_\_\_

# Satilla

Family Dentistry

Do you have a personal physician?     Yes     No

Physician's Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Your current physical health is:     Good     Fair     Poor

Are you currently under the care of a physician?     Yes     No

Please explain: \_\_\_\_\_

Do you use tobacco in any form?     Yes     No

Have you had any metal rods, pins, or implants placed?     Yes     No

Are you taking any medications?     Yes     No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?     Yes     No

Please list each: \_\_\_\_\_

- | Yes                      | No                       | <u>Conditions</u>       |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding       |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse           |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris         |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing    |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse              |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema               |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Surgery          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters          |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches      |

- | Yes                      | No                       | <u>Conditions</u>            |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                     |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV + AIDS                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C                  |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure          |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement            |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems              |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure           |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems         |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever              |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles                     |

- | Yes                      | No                       | <u>Conditions</u>   |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems      |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke              |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems    |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers              |
| <input type="checkbox"/> | <input type="checkbox"/> | Bisphosphonates     |

- | Yes                      | No                       | <u>Allergies</u>   |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin            |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine            |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin       |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry            |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex              |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals             |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin         |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline       |

- | Yes                      | No                       | <u>If Female, please answer</u>     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?                   |
|                          |                          | Is so, # of Weeks: _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing?                    |

Emergency Contact:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

How can we help you today? \_\_\_\_\_

Your current dental health is:     Good     Fair     Poor

Do you require antibiotics before dental treatment?     Yes     No

If so, why? \_\_\_\_\_

Are you currently in pain?     Yes     No

Have you ever had gum treatment?     Yes     No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)     Yes     No

Are you under stress? (new job, moving, relationship)     Yes     No

Do you like your smile?     Yes     No

Is there anything you would like to change about your smile?     Yes     No

Are you happy with the color of your teeth?     Yes     No

Do your gums bleed?     Yes     No

How many times do you:    floss/week? \_\_\_\_\_    brush/day? \_\_\_\_\_

Are your teeth sensitive to heat, cold, or anything else?     Yes     No

Have you lost any teeth?     Yes     No

Have you ever had a serious/difficult problem with any previous dental work?     Yes     No

Have you ever had any unfavorable dental experiences?     Yes     No

When was your last dental cleaning? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

How can we accommodate you better during your dental visit? \_\_\_\_\_

Here at Satilla Family Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening

Veneers

Night/Sport Guards

Sealants

Smile Makeover

Bonding

Partials/Dentures

Crown and Bridge

Implant Crowns



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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse To Sign This Acknowledgement

I, \_\_\_\_\_, have received a copy of  
this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
**For Office Use Only**  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices,  
but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_