KENNESTONE PERIODONTICS

Practice Limited to Periodontics and Dental Implants

2501 Windy Hill Road
Suite 200
Marietta, GA 30067
(770) 952-5432

611 Campbell Hill Street
Suite 102
Marietta, Georgia 30060
(770) 422-0642

Date _____ **GA DL #** _____

Patient Name _____ **SS#** _____

Patient Address _____ **Date of Birth** _____ **Age** _____

City, State, ZIP _____ **Marital Status** _____ **Sex** _____

Home Phone _____ **Work Phone** _____ **Cell** _____

Email _____

Place of Employment _____ **Occupation** _____

Employer's Address _____

Spouse's Name _____ **SS#** _____

Spouse's Employer _____ **Date of Birth** _____

Person Responsible For Account _____

Do You Have Dental Insurance ? ☐ **Yes** ☐ **No** **Name of Insured** _____

Insurance Company _____ **Policy #** _____

Are You Covered on Spouse's Insurance ? ☐ **Yes** ☐ **No**

Insurance Company _____ **Policy #** _____

Do You Have Medical Insurance ? ☐ **Yes** ☐ **No** **Name of Insured** _____

Insurance Company _____ **Policy #** _____

In Case of EMERGENCY Call _____ **Phone #** _____

Who Referred You To Our Office ? _____

Did You Bring X-Rays ? ☐ **Yes** ☐ **No** **Have They Been Mailed ?** ☐ **Yes** ☐ **No**

Is Any Member of Your Immediate Family A Patient Here ? ☐ **Yes** ☐ **No**

Name _____

I, the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances and accounts over sixty (60) days will be charged a service charge of 1.5% per month (18% annually) on the unpaid balance due. Any professional courtesy will be added back to the account. The cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to your balance due.

_____

Signature of Person Responsible for Account

PLEASE TURN TO LAST PAGE AND
COMPLETE THE MEDICAL HISTORY

Kennestone Periodontics, PC HEALTH HISTORY

PHYSICIAN: _____ OFFICE PHONE: _____ DATE OF LAST PHYSICAL: _____

	YES	NO
Are You Under Medical Care Now?	☐	☐
Have You Had Any Major Operations?	☐	☐

If Yes, Explain:

CARDIOVASCULAR:		
Rheumatic Fever	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Murmur	☐	☐
Congenital Heart Defect	☐	☐
Angina or Heart Attack	☐	☐
Stroke	☐	☐
Congestive Heart Failure	☐	☐
Heart Surgery or Pacemaker	☐	☐
High or Low Blood Pressure	☐	☐
RESPIRATORY:		
Asthma or Bronchitis	☐	☐
Emphysema	☐	☐
Hay Fever / Sinus Issues	☐	☐
Shortness of Breath	☐	☐
ENDOCRINE:		
Diabetes	☐	☐
High or Low Thyroid Disease	☐	☐
Parathyroid Disease	☐	☐
BLOOD:		
Anemia	☐	☐
Excessive Bleeding	☐	☐
TAKE BLOOD THINNER OR ASPIRIN	☐	☐
Leukemia	☐	☐
Blood Transfusion	☐	☐

	YES	NO
KIDNEY:		
Kidney Infection	☐	☐
Kidney Surgery	☐	☐
Dialysis	☐	☐
INFECTIOUS DISEASES:		
Hepatitis	☐	☐
Venereal Disease	☐	☐
Tuberculosis (TB)	☐	☐
HIV	☐	☐
Herpes / Recurrent Cold Sores	☐	☐
MISCELLANEOUS:		
Fainting	☐	☐
Liver Disease	☐	☐
Arthritis	☐	☐
Ulcers	☐	☐
Glaucoma	☐	☐
Cancer / Radiation / Chemotherapy	☐	☐
Bisphosphonates	☐	☐
Epilepsy / Seizures	☐	☐
Phychiatric Treatment	☐	☐
Do you smoke?	☐	☐
How Much?		
Do Your Ankles Swell?	☐	☐
Do You Sleep Inclined?	☐	☐

Are You Taking Any Medication? If Yes, What? _____

	YES	NO
Are You In Good health At This Time?	☐	☐
Have Any Wounds Healed Slowly, Do You Bruise Easily? Any Complications From Surgery?	☐	☐
Persistent Swollen Glands In Your Neck?	☐	☐
History of Fainting or Seizures?	☐	☐
Abnormal Bleeding or Require Blood Transfusion?	☐	☐
Joint Replacement Surgery or Implanted Devices?	☐	☐
Drug or Alcohol Abuse?	☐	☐
Persistent Diarrhea or Unusual Weight Loss?	☐	☐
Allergies to Medicines?	☐	☐
Local or General Anesthesia?	☐	☐
Penicillin or other Antibiotics?	☐	☐
Aspirin Codeine	☐	☐
Iodine Barbiturates Sedatives or Sleeping Pills	☐	☐
Other Drugs Not Listed _____	☐	☐
Any Other Conditions NOT Listed that you feel your Doctor Should Know About? _____	☐	☐

WOMEN:

Are You Pregnant, May Be Pregnant, or Trying to Become Pregnant? If Yes, How Many Months? _____	☐	☐
Are You Nursing?	☐	☐
Are You Taking Birth Control Pills?	☐	☐

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I, the undersigned , have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

Patient/Guardian Signature **Date**

Doctor's Signature **Date**