Welcome

Robert P. Hortman / A. Kyle Carney
15 professional Court • Rome, GA 30165
Tel. (706) 291-0555 • Fax (706) 291-3734

Date: _____

Preferred Dentist:
☐ Robert P. Hortman
☐ A. Kyle Carney

We are pleased to welcome you to our practice.
Please fill out this form and bring with you to your consultation.
We look forward to working with you.

Patient Information

Name_____ Soc. Sec. #_____
Last Name *First Name* *Initial*

Address_____ Cell phone #_____

City_____ State_____ Zip_____ Phone_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____ Dentist_____

Notify in case of emergency_____ Home Ph._____ Work Ph._____

Person Responsible for Account_____

IF PATIENT IS A MINOR / OTHER PARENT INFORMATION

Relation to Patient_____ Birthdate_____ Soc. Sec #_____

Name_____ D.O.B._____

Address_____ Phone_____

Business Address_____ Business Phone_____

Primary Dental Insurance

Insured's Name_____ Relation to Patient_____ Insured's Birthday_____

Address (if different from patient)_____ Soc. Sec. #_____

City_____ State_____ Zip_____ Phone_____

Insured Employed by_____ Business Phone_____

Employer Address_____

Please provide copy of Insurance card

*** I understand there is a refile charge for incorrect insurance information**

Acknowledgement of Privacy Practices

Patient Name _____ D.O.B. _____

Contact Phone No(s) Home _____ Work _____ Cell _____

Medical Information and / or Test Results can be given to:

_____ No one except myself

_____ The following person(s) _____

Leave message on answering machine / voicemail ☐ Yes ☐ No

Signature _____ Date _____ Initial _____

(OVER)

Patient Information

How can we help you with your dental needs? _____

Date of last dental care _____

Do you now or have you ever experienced pain or discomfort in your jaw joint? ☐ Y ☐ N

On a scale of 1-10 (10 being highest), what priority do you give your teeth? _____

Do you usually breathe through your mouth while awake? ☐ Y ☐ N Or asleep? ☐ Y ☐ N

Have you ever experienced an adverse reaction during a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses (hospitalizations or surgeries) ☐ Y ☐ N

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____

Women: Are you pregnant? ☐ Y ☐ N

LIST MEDICATION YOU ARE TAKING, IF ANY:

_____

_____

_____

_____

LIST DRUG ALLERGIES, IF ANY:

_____

_____

_____

_____

Check (✓) if you have had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems

Describe _____

- ☐ Hemophilia / Abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease or Malfunction
- ☐ Liver disease
- ☐ Material Allergies (latex, wool, metal, chemicals)
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker / Heart surg.
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic / Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer / Colitis
- ☐ Venereal disease

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any change in medical status, I will inform the Dentist.

I authorize the insurance company indicated on this form to pay to the Dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the Dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.