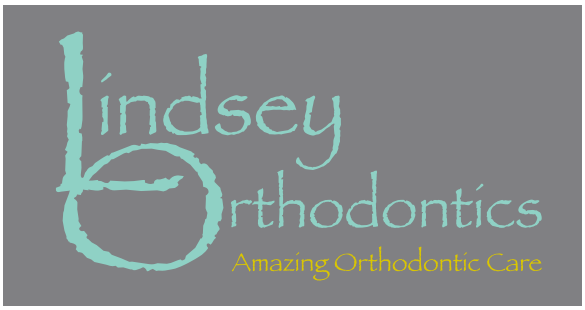

120 West College St.
Suite A
Griffin, GA 30224
P: 770-228-1223
F: 770-228-8577

4600 Bill Gardner Parkway
Suite 100
Locust Grove, GA 30248
P: 770-914-7994
F: 770-914-7985

Patient Information

This appointment is for ☐ Yourself ☐ Your Child

Name _____ Social Security #_____

Preferred Name _____ Age _____ Gender _____ Birthdate _____

Address _____ City_____ State_____ Zip_____

Primary Phone _____ Email_____

Whom may we thank for referring you? _____

Responsible Party

Who is responsible for this patient?

Full Name _____ Social Security #_____

Birth Date _____ ☐Male ☐Female Relation to Patient _____

Address _____ City_____ State_____ Zip_____

Cell Phone _____ Carrier_____ Email _____

Insurance Information

Dental Coverage ☐ Yes ☐ No

Insured's Name_____ Relation _____

Address_____ City_____State_____ Zip_____

Insured's Social Security #_____ Birthdate _____

Insurance Company_____Group #_____

Insurance Phone _____ Employer _____

Secondary Insurance Information

Insured's Name_____ Relation _____

Address_____ City_____State_____ Zip_____

Insured's Social Security #_____ Birthdate _____

Insurance Company_____Group #_____

Insurance Phone _____ Employer _____

MEDICAL HISTORY *Please complete this page before turning in.

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Cerebral Palsy
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Endocrine Disorders
- ☐ Epilepsy (Convulsions)
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Murmur/Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV infection
- ☐ Kidney Disorders
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Neurologic Disorders
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Tonsil or Adenoid Removal
- ☐ Tuberculosis

PATIENT'S PHYSICIAN _____

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN _____

_____

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

_____

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES OR NO) _____

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE _____

_____

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

- ☐ Bleeding Gums
- ☐ Chronic Facial Pain
- ☐ Clenching or Grinding of Teeth
- ☐ Difficulty Chewing or Swallowing
- ☐ Dizziness
- ☐ Frequent Headaches
- ☐ Injuries to Face or Teeth
- ☐ Jaw Joint Pain
- ☐ Jaw Joints Pop or Click
- ☐ Jaw Locking Open or Closed
- ☐ Limitation in Mouth Opening
- ☐ Missing or Extra Permanent Teeth
- ☐ Mouth Breathing
- ☐ Muscle Tenderness in Jaw or Neck
- ☐ Nail Biting
- ☐ Periodontal Surgery
- ☐ Permanent Teeth Removed
- ☐ Speech Problems
- ☐ Sucks Thumb, Finger or Lip
- ☐ Teeth Sensitivity - Hot/Cold
- ☐ Tongue Thrust

PATIENT'S DENTIST _____ PATIENT'S DENTIST'S ADDRESS _____

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT _____

HAS THE PATIENT RECEIVED AN EVALUATION OR TREATMENT IN ANOTHER ORTHODONTIC OFFICE? (YES OR NO) _____

IF YES, BY WHOM? _____

LIST THE PATIENT'S CHIEF CONCERNS AND WHAT THEY WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH _____

_____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Lindsey and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment.

I give permission to Lindsey Orthodontics to use my child's photo on Social Media ☐ Yes ☐ No

I have received and read the HIPAA consent form _____
SIGNATURE

I understand that, where appropriate, credit bureau reports may be obtained.

SIGNATURE _____ **DATE** _____