



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

Patient Full Name _____ Social Security # _____

Nickname _____ Age _____ Male Female Birthdate _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Email _____

Full-time Student Yes No School Name _____

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 _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

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

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

- | | | | | | |
|--------------------------|--|-----------------------------|--|---------------------------|--|
| AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocrine Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy (Convulsions) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurologic Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur/Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsil or Adenoid Removal | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Chronic Facial Pain | <input type="checkbox"/> Jaw Joints Pop or Click | <input type="checkbox"/> Periodontal Surgery |
| <input type="checkbox"/> Clenching or Grinding of Teeth | <input type="checkbox"/> Jaw Locking Open or Closed | <input type="checkbox"/> Permanent Teeth Removed |
| <input type="checkbox"/> Difficulty Chewing or Swallowing | <input type="checkbox"/> Limitation in Mouth Opening | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Missing or Extra Permanent Teeth | <input type="checkbox"/> Sucks Thumb, Finger or Lip |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Teeth Sensitivity - Hot/Cold |
| <input type="checkbox"/> Injuries to Face or Teeth | <input type="checkbox"/> Muscle Tenderness in Jaw or Neck | <input type="checkbox"/> 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 Facebook Yes No

I have received and read the HIPAA consent form _____
SIGNATURE

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

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ DATE _____