

# Alpharetta Aesthetic Dental Studio

**Stephen P. Leafe D.D.S.**  
**30 Milton Avenue**  
**Alpharetta, GA 30004**  
 (770)-475-9630

## PATIENT INFORMATION

Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

**Name you prefer to be called** \_\_\_\_\_  Male  Female Drivers License # \_\_\_\_\_

Check Appropriate Boxes:  Minor  Single  Married  Divorced  Widowed  Other

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

FAX# \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ **Referred to our office by** \_\_\_\_\_

Spouse Name \_\_\_\_\_ Work phone \_\_\_\_\_

Name of Person Responsible for this Account \_\_\_\_\_ Home phone \_\_\_\_\_  
 (if different than above)

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Is this Person currently a Patient in our office?  Yes  No

**Have you ever had any of the following? Please check those that apply:**

- |  |  |  |   |                                    |
|--|--|--|---|------------------------------------|
| <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Thyroid              | MEDICATION                         |
| <input type="checkbox"/> Latex/Rubber Allergy  | <input type="checkbox"/> Fainting/Seizures     | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Sinus Problems       | (Presently taking)                 |
| <input type="checkbox"/> Codeine Allergy       | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Tumors               | _____                              |
| <input type="checkbox"/> Penicillin Allergy    | <input type="checkbox"/> Growths               | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Ulcers               | _____                              |
| <input type="checkbox"/> Erythromycin Allergy  | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Angina              | <input type="checkbox"/> Venereal Disease     | _____                              |
| <input type="checkbox"/> Head Injuries         | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Swollen Ankles      | <input type="checkbox"/> Frequently tired     | Other                              |
| <input type="checkbox"/> Artificial Joint      | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | _____                              |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Rheumatism           | _____                              |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach Problems    | <input type="checkbox"/> Hepatitis - Type     | _____                              |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Jaw Joint Pain       | _____                              |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Liver Disease        | _____                              |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Epilepsy/Convulsion   | <input type="checkbox"/> Herpes/STD          | <input type="checkbox"/> Joint Replacement    | <input type="checkbox"/> Allergies |

• Have you been treated for weight loss with Redux or Phen-Fen?  Yes  No

• Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.**

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

**Please check those that apply:**

- |   | YES                      | NO                       |   | YES                      | NO                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing/flossing?                          | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot/cold?                                | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet/sour?                              | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain on any of your teeth?                               | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Any sores or lumps in your mouth?                                    | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?                         | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? |                          |                          | 14. Do you wear dentures or partials?<br>If yes, date of placement _____              | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking  | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you received oral hygiene instructions regarding care of your teeth or gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face)   | <input type="checkbox"/> | <input type="checkbox"/> | 16. DO YOU LIKE YOUR SMILE?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| Difficulty in chewing   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

Have you ever had any complications following dental treatment?  
If yes, please explain: \_\_\_\_\_

- |   |                          |                          |   |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 17. Are you allergic to or have you had any reactions to the following? |                          |                          | 18. Women only                          |                          |                          |
| Local Anesthetics (eg. Novocaine)                                       | <b>YES</b>               | <b>NO</b>                | a) Are you or think you may be pregnant | <b>YES</b>               | <b>NO</b>                |
| Any Metals (e.g. nickel, mercury, etc)                                  | <input type="checkbox"/> | <input type="checkbox"/> | b) Are you nursing?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are you wearing contact lenses?                                     | <input type="checkbox"/> | <input type="checkbox"/> | c) Are you taking oral contraceptives?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you use tobacco?   | <input type="checkbox"/> | <input type="checkbox"/> |   | <input type="checkbox"/> | <input type="checkbox"/> |

**I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.**

**X** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of patient (or parent if minor)**

Doctor's Comments: \_\_\_\_\_  
Date: \_\_\_\_\_

**MEDICAL HISTORY UPDATE**

Medical history updated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature of Patient

Medical history updated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature of Patient

Medical history updated \_\_\_\_\_ and confirmed that it states past and present medical conditions. \_\_\_\_\_  
Signature of Patient

***Take advantage of our gift to you!!!!***

If you or your family refer a patient to our office, we will credit your account in the amount of \$20.00 available towards your next dental visit. Just tell your friends about our office and the quality care we provide and make sure that the referred person mentions your name at the time of their appointment.

**Thank you for your confidence!**

### Insurance Information

**Our office will file your insurance claims as a NO COST courtesy to you. This in no way implies that this office is responsible for collecting fees from the insurance company for services rendered. It is the sole responsibility of the patient or guardian of the patient to pay the fees for services rendered. We will assist you the best we can in understanding your insurance benefits based on the plan information you provide. Accounts over 90 days are subject to a 2% re-billing charge.**

Policy Holder's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Insurance Company Phone# \_\_\_\_\_

### AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_

Signature of patient (or parent if minor)

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DO YOU HAVE SECONDARY COVERAGE?  YES  NO IF YES, COMPLETE THE FOLLOWING:

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Policy Holder's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Insurance Company Phone# \_\_\_\_\_