



NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Why have you made this dental appointment? \_\_\_\_\_
Have you left a previous dentist? Yes No If so, why? \_\_\_\_\_
Are you in pain or discomfort at this time? Yes No If so, where? \_\_\_\_\_

Obstacles I see to excellent dental health for myself: (please circle all that apply)

I see no obstacles Time away from work or other obligations Fear of pain, surgery, or injections
Fear because of past dental experiences Cost of treatment Other \_\_\_\_\_

I believe my present DENTAL health is: Excellent Good Poor

Please circle the appropriate answer:

- 1. Do you use tobacco products... Yes/ No
2. Do you have sensitive teeth?... Yes/ No
3. Would like to improve the appearance of my teeth ..... Yes/ No
4. Do you frequently suck on hard candy or mints?... Yes/ No
5. Avoid chewing on one side of mouth... Yes/ No
6. Been told you have periodontal disease... Yes/ No
7. Gums bleed when brushing?... Yes/ No
8. Unusual/frequent jaw or ear aches?... Yes/ No
9. Have a habit of grinding/clenching your teeth?... Yes/ No
10. Do you have severe or frequent headaches?... Yes/ No
11. Have you worn braces?... Yes/ No
12. Do you get cold sores/fever blisters on your lips?... Yes/ No
13. Do you get canker sores/mouth ulcers?... Yes/ No

Please list all medications and dosages that you take (prescriptions and over-the-counter): \_\_\_\_\_

(continue list on separate page if necessary)

Are you allergic to or have difficulty with any of the following substances? Penicillin Tetracycline Latex Aspirin Codeine
Dental Anesthetic Sulfa Erythromycin Other Substances \_\_\_\_\_

For Women: Are you pregnant? Yes/No

Are you nursing? Yes/No

Are you taking birth control pills? Yes/No

I believe my current MEDICAL health is: Excellent Good Poor

Have you been hospitalized in the last 5 years? Yes No If Yes, reason? \_\_\_\_\_

Please list the names and phone numbers of physicians what are currently providing you care:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
3. \_\_\_\_\_ 4. \_\_\_\_\_

For the following questions, circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Table with 6 columns: Question, Yes, No, Question, Yes, No. Rows include Heart Murmur, Rheumatic Fever, History of Heart Attack, High Blood Pressure, History of Heart Surgery, History of Rheumatic Fever, Chest Pain or Angina, Abnormal Heart Condition, Stroke, Diabetes, Hepatitis, HIV Positive or AIDS Related Complex, Thyroid Problems, Emphysema/Respiratory Disease, Unintentional Weight Loss/Gain, Venereal Disease, Liver Disease, History of Psychiatric Treatment, Glaucoma, Arthritis, Epilepsy, History of Cancer, Hemophilia, History of Drug or Alcohol Addiction, Tuberculosis, Seasonal Allergies/Hay Fever.

Doctor's Use Only \_\_\_\_\_

CONSENT:

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take x-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness together with any collection costs and attorney fees as may be required to effect collection

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Or Responsible Party)

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE BOTH SIDES OF THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE		
NAME NAME I LIKE TO BE CALLED		
MAILING ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE		WORK PHONE - EXT.
SOCIAL SECURITY #:	CELL PHONE	
BIRTH DATE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
MARITAL STATUS		
SPOUSE'S NAME		

PARENT OR GUARDIAN RESPONSIBLE FOR CHILD'S ACCOUNT

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE		
CHILD'S NAME NICK NAME		
MAILING ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE		
BIRTH DATE	AGE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SCHOOL	GRADE	
The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.		
Signature of Parent or Guardian		DATE

<b>DENTAL INSURANCE</b>	
<b>PRIMARY CARRIER</b>	
INSURANCE COMPANY	
EMPLOYEE	
DATE OF BIRTH	
GROUP NO.	
EMPLOYER PROVIDING INSURANCE	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
<b>SECONDARY CARRIER</b>	
INSURANCE COMPANY	
EMPLOYEE	
DATE OF BIRTH	
GROUP NO.	
EMPLOYER PROVIDING INSURANCE	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.	
Signed ( Patient or Parent if Minor) _____ DATE _____	
I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.	
Signed ( Insured Person) _____ DATE _____	

<b>ACCOUNT INFORMATION</b>		
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
DRIVERS LICENSE NO.	RELATIONSHIP TO PATIENT	
ACCEPTABLE FORMS OF PAYMENT:		
<input type="checkbox"/> CASH	<input type="checkbox"/> PERSONAL CHECK	<input type="checkbox"/> MASTERCARD / VISA
PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.		
<b>YOU:</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	
<b>YOUR SPOUSE:</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	

<b>GETTING TO KNOW YOU</b>		
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
THEIR NAME:		
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		
DO YOU HAVE ANY SPECIAL INTERESTS, SPORTS OR HOBBIES?		
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
NAME	PHONE	
ADDRESS		
CITY	STATE	ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
NAME	PHONE	
ADDRESS		
CITY	STATE	ZIP

OVER

Atlanta West Family Dentistry  
Dr. Travis Watson and Dr. Cameron Watson  
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770-941-6979 / fax 770-732-6292

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*You may refuse to sign this acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment plan directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and provider certifications

I acknowledge that I may request to receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice or Privacy Practices. I understand that the provider is not required to agree to my requested restrictions, but if agreed, then the provider is bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

or

Guardian Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so for the reasons below:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- Other (Please Specify) \_\_\_\_\_

Personnel  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Atlanta West Family Dentistry**  
**Cancellation/Failed Appointment Policy**

You are the only one scheduled for your appointment time. Your appointment time is important to you, and others who are in need of our services.

**If you cannot keep your appointment for any reason, please call 24 hours prior to your appointment time.** If you do not show for your appointment or cancel with less than 24 hours notice, **a fee of \$75 will be charged to your account.** You will be personally responsible for this charge. This charge will not be billed to your insurance company. Future appointments will not be scheduled until this fee is paid.

Please help us keep the scheduling of appointments fair for everyone. Thank you.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name