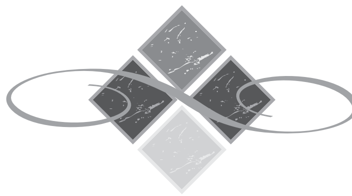
218 Addevale Street

Griffin, Georgia 30224

770/227-1296 office

770/228-5262 fax



DOUGLAS C. KALLIS DMD · PC

Orthodontics Exclusively

Date

A B C

PATIENT INFORMATION E-MAIL: ____________

PATIENT'S NAME ____________ (LAST / FIRST / MIDDLE) SEX: ◇ M ◇ F

ADDRESS ____________ (STREET / CITY / STATE / ZIP)

HOME PHONE ( ) ____________ BIRTHDATE ____________ SOCIAL SECURITY # ____________

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME ____________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

NAME ____________ (LAST / FIRST / MIDDLE) MARITAL STATUS ____________

RESIDENCE ____________ (STREET / CITY / STATE / ZIP) ☐ RENT ☐ OWN

MAILING ADDRESS ____________ (STREET / CITY / STATE / ZIP)

HOW LONG AT THIS ADDRESS? ____________ PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) ____________

HOME PHONE ( ) ____________ WORK PHONE ( ) ____________ CELL PHONE ( ) ____________

SOCIAL SECURITY # ____________ BIRTHDATE ____________ RELATIONSHIP TO PATIENT ____________

EMPLOYER ____________ OCCUPATION ____________ YEARS EMPLOYED ____________

SPOUSE'S NAME ____________ RELATIONSHIP TO PATIENT ____________

EMPLOYER ____________ OCCUPATION ____________ YEARS EMPLOYED ____________

SOCIAL SECURITY # ____________ BIRTHDATE ____________ CELL PHONE ( ) ____________

INSURANCE INFORMATION

INSURED'S NAME ____________ (LAST / FIRST / MIDDLE) SOCIAL SECURITY # ____________

EMPLOYER'S NAME ____________ BIRTHDATE ____________

INSURANCE COMPANY ____________ GROUP # ____________ MEMBER ID # ____________

INSURANCE COMPANY ADDRESS ____________ (STREET / CITY / STATE / ZIP)

DO YOU HAVE DUAL COVERAGE? ____________ IF YES: ____________

INSURED'S NAME ____________ (LAST / FIRST / MIDDLE) SOCIAL SECURITY # ____________

EMPLOYER'S NAME ____________ BIRTHDATE ____________

INSURANCE COMPANY ____________ GROUP # ____________ MEMBER ID # ____________

INSURANCE COMPANY ADDRESS ____________ (STREET / CITY / STATE / ZIP)

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH THE PATIENT ____________

COMPLETE ADDRESS ____________ (STREET / CITY / STATE / ZIP)

HOME PHONE ( ) ____________ SPECIAL NOTES ____________

MEDICAL HISTORY

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

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

____

DEVELOPMENTAL HISTORY

PATIENT'S HEIGHT ____________ PATIENT'S WEIGHT ____________ FATHER'S HEIGHT ____________ MOTHER'S HEIGHT ____________

HAS PATIENT REACHED PUBERTY?______ GIRLS: STARTED MENSTRUATING?_____ IF YES, WHEN? ______________________________

BOYS: VOICE CHANGED?__________ IF YES, WHEN? ______________________________

IS PATIENT ADOPTED? ____________________

DENTAL HISTORY

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

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

PATIENT'S DENTIST ______________________________

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. Kallis and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment.

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

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) ______________________________ **DATE** ______________

FOR OFFICE USE
UPDATES (DATE AND INITIAL)