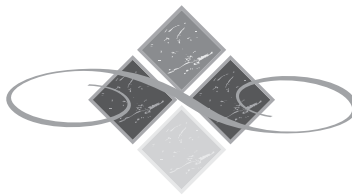




218 Addevale Street
 Griffin, Georgia 30224
 770/227-1296 office
 770/228-5262 fax



DOUGLAS C. KALLIS DMD · PC
Orthodontics Exclusively

Date _____

A B C

PATIENT INFORMATION E-MAIL: _____

PATIENT'S NAME _____ SEX: M F
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE () _____ BIRTHDATE _____ SOCIAL SECURITY # _____

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

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

NAME _____ MARITAL STATUS _____
LAST FIRST MIDDLE

RESIDENCE _____ RENT OWN
STREET CITY STATE ZIP

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 _____ WORK PHONE () _____

INSURANCE INFORMATION

INSURED'S NAME _____ SOCIAL SECURITY # _____
LAST FIRST MIDDLE

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 _____ SOCIAL SECURITY # _____
LAST FIRST MIDDLE

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 YOU _____

COMPLETE ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE () _____ SPECIAL NOTES _____

MEDICAL HISTORY

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN "YES")

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

YOUR PHYSICIAN _____

STATE ANY REASONS WHY YOU ARE CURRENTLY UNDER THE CARE OF A PHYSICIAN _____

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

HAVE YOU 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

DO YOU 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 |

YOUR DENTIST _____

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT _____

HAVE YOU RECEIVED AN EVALUATION OR TREATMENT IN ANOTHER ORTHODONTIC OFFICE? (YES OR NO) _____

IF YES, BY WHOM? _____

LIST YOUR CHIEF CONCERNS AND WHAT YOU 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 medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my 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 _____ DATE _____

FOR OFFICE USE
UPDATES (DATE AND INITIAL)