Michael O Vernon D.M.D. **Christopher M Moldovan D.M.D**

Augusta Dental Associates

1218 Augusta West Parkway
Augusta, GA 30909

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointments, or fees, please feel free to ask.

(Please Print) Today's Date: _____ Patients Date of Birth: _____

Name:

_____

(Last) (First) (Preferred name) (Marital Status) (Spouse's Name)

Person responsible for payment of service rendered (guardian) _____

Residence Address: _____

(City) (State) (Zip)

Email Address: _____

Telephone: Home _____Work _____Cell _____Social Security No: _____

Name of Business: _____Position:_____

Business Address: _____

(City) (State) (Zip)

Insurance

(PLEASE READ THOROUGHLY)

As a courtesy to you, we can take assignment of your dental insurance benefits. To accurately file your claims, please present your dental insurance card and complete the following information.

INFORMATION ABOUT THE PERSON WHO CARRIES THE DENTAL INSURANCE: Name: _____

Social Security No.: _____ Date of Birth: _____

Dental Insurance Carrier: _____

Employer: _____Group Policy or Union No: _____

Address to mail completed insurance claim: _____

_____

Your total balance charged and dental insurance is your financial responsibility, but we can help. If you wish for us to file your dental insurance, we must ask that you be prepared after each visit to pay the *ESTIMATED* amount that the insurance will not cover based on the information provided by your insurance company.

I hereby authorize the release to and the use by Michael O. Vernon, D.M.D., P.C. any dental or other information needed in processing the claims resulting from treatment rendered in this office.

_____
Signed (patient) date

I hereby authorize the payment of dental benefits directly to Michael O. Vernon, D.M.D., P.C. Christopher M. Moldovan, D.M.D., P.C.

_____
Signed (insured) date

PLEASE SEE OTHER SIDE

MICHAEL O. VERNON, D.M.D., P.C.
CHRISTOPHER MOLDOVAN, D.M.D.
1218 Augusta West Parkway
AUGUSTA, GA 30909

I understand that all fees incurred by my dependents or myself regardless of insurance coverage, is my responsibility and I will be liable for payment of these charges.

_____ _____

Signature of Guarantor of Account Date

MEDICAL HISTORY

(1) How would you classify your General Health (circle one)? **Excellent Good Fair Poor**

(2) Are you presently under the care of a physician? If yes, for what? _____

(3) Personal Physician _____Address/Phone _____

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment. PLEASE CHECK THE APPROPRIATE BOX for any conditions that you have now or had in the past.
(Parent/Guardian: Please check the appropriate boxes concerning your child's health status)

Cardiovascular (Heart)	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
If so When? _____		
Angina/Chest Pain	☐	☐
Take Coumadin	☐	☐
Take Daily Aspirin	☐	☐
Artificial Cardiac Valves	☐	☐
Previous Infective Endocarditis	☐	☐
Congenital Heart Defect	☐	☐
Mitral Valve Prolapse	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
If so, when? _____		
Other Heart Problems	☐	☐
What, _____		

Have you been instructed to premedicate with antibiotics prior to all dental treatment for any health related conditions (such as Artificial Valves, Artificial Joints, Previous Heart Infection, etc…)?
Yes ☐ **No** ☐

Nerves & Sensory	Yes	No
Severe Headaches	☐	☐
Fainting / Dizzy Spells	☐	☐
Epilepsy / Seizures	☐	☐
Nervousness	☐	☐
Dental Anxiety	☐	☐
Respiratory (Breathing)		
Sinus Problems	☐	☐
Allergies or Hives	☐	☐
Asthma	☐	☐
Use inhaler? _____		
Tuberculosis (TB)	☐	☐
Dermal/Musculoskeletal		
Allergy to Latex	☐	☐
Joint Replacement	☐	☐
Sore Jaw Muscles / Joints	☐	☐
Arthritis	☐	☐
Mouth Ulcers / Sores	☐	☐
Gastrointestinal (Stomach)		
Ulcers	☐	☐
Liver Disease/Failure	☐	☐
Hepatitis	☐	☐
When? Type? _____		

Endocrine (Hormonal)	Yes	No
Diabetes	☐	☐
Take Insulin? _____		
Thyroid Disease	☐	☐
Hematologic (Blood)		
Stroke	☐	☐
If so, when? _____		
Anemia	☐	☐
Prolonged Bleeding	☐	☐
Leukemia	☐	☐
HIV / AIDS Positive	☐	☐
Urinary		
Kidney Disease/Failure	☐	☐
Other Conditions		
Use Tobacco	☐	☐
Drug Dependency	☐	☐
Tumor / Cancer	☐	☐
Radiation / Chemotherapy	☐	☐
Immunosuppression	☐	☐
Organ Transplant	☐	☐

Have you ever taken medication for **Osteoporosis/Bone Disease** to increase bone density (i.e. **Fosamax, Boniva, Actonel, Aredia, Zometa, Reclast**) **Yes** ☐ **No** ☐

Are you taking (or supposed to be taking) any medicine, drugs or pills of any kind (including Aspirin / non-prescription drugs)?
Yes ☐ **No** ☐ If so, what?

Are you allergic to any drugs or medicines (**Including anesthetic**)? **Yes** ☐ **No** ☐ If so, what drug?/What type of reaction did you have?

Please list any other medical conditions or concerns not mentioned above that the Doctor should be aware of:

WOMEN: Are you pregnant? **Yes** ☐ **No** ☐ How long (circle one)? **1-3 months 3-6 months 6-9 months**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment.

_____ _____
Date Patient, Parent or Guardian Signature

Please See Other Side →

DENTAL HISTORY

(1) What prompted you to seek dental care at this time? _____

_____

(2) On a scale of 1 to 10 (10 being the highest), what priority do you give your teeth? 1 2 3 4 5 6 7 8 9 10
(3) Have you experienced any discomfort from your teeth or gums lately? ..... Yes No
(4) Have you noticed any popping, clicking or tiredness of your jaw joint? ..... Yes No
(5) Do you have any missing teeth that have not been replaced? ..... Yes No
(6) Do you feel that you cannot chew well? ..... Yes No
(7) When did you last have x-rays taken of your teeth? _____ Last cleaning? _____
(8) Do you receive any type of fluoride? ..... Yes No
(9) The name and address/phone number (if available) of your former dentist: _____

_____

(10) Why did you choose our office for your dental needs? _____

_____

(11) Whom may we thank for referring you to our office? _____

PREVENTIVE DENTAL HISTORY

(1) Have you been taught proper brushing methods? ..... Yes No
(2) Have you been taught proper flossing methods? ..... Yes No
(3) Do your gums bleed easily, especially when you clean them? ..... Yes No
(4) Do you have any problems with bad breath? ..... Yes No
(5) Have you ever been told you have gum disease (Pyorrhea)? ..... Yes No

(6) Is there anything you feel we should know to help us in your treatment? _____

Augusta Dental Associates
Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

This is to certify that I have received a copy of this office's Notice of Privacy Practices
(See attached brochure)

_____ _____ _____

(Please Print Name)

(Signature) (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please Specify) _____