Dr. Laurie A. Deemer
2104 Newton Drive NE
Covington, Georgia 30014

WELCOME TO OUR OFFICE

Patient _____ Today's Date _____
(Last) (First) (MI) (Nickname)

Date of Birth _____ __ Married __ Single __ Divorced __ Separated __ Widowed __ Minor

If A Child, Parent's Name _____ Patient's Sex __ Male __ Female

If Married, Spouse's Name _____

Patient's Home Address _____
(Street) (City) (State) (Zip)

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Social Security # _____ E-Mail Address _____

Patient (or Parent) Employed By _____ Occupation _____

Business Address _____
(Street) (City) (State) (Zip)

In Case of Emergency, Closest Relative Not Living With You _____

Emergency Contact Phone (____)_____ How Did You Hear About Us? _____

INSURANCE INFORMATION

Person Responsible For This Account (Name Of Insured) _____

Social Security # _____ Relationship to Patient _____

Date of Birth _____ Person Responsible Employed by _____

Business Address _____

Business Phone (____)_____ Home Phone (____)_____ Occupation _____

Name of Dental Insurance _____ Group # _____

Home Address (if different than patient's) _____

Is Patient Covered by Additional Dental Insurance? ___ Yes ___ No

Secondary Insurance Company _____ Group # _____

Name of Insured _____ Social Security # _____

Employed by _____ Date of Birth _____

(Please complete **BOTH** sides)

MEDICAL HISTORY

Physician's Name _____ Phone (____)_____ Last Physical_____

Do you have or have you ever had any of the following:

___ Yes ___ No Anemia
___ Yes ___ No Arthritis
___ Yes ___ No Asthma
___ Yes ___ No Back Problems
___ Yes ___ No Cancer
___ Yes ___ No Chemical Dependency
___ Yes ___ No Chemotherapy/Radiation
___ Yes ___ No Diabetes (Type _____)
___ Yes ___ No Epilepsy
___ Yes ___ No Fainting/Dizziness
___ Yes ___ No Glaucoma
___ Yes ___ No Heart Problems
___ Yes ___ No Hemophilia/Clotting Problems
___ Yes ___ No Hepatitis/Liver Disease
___ Yes ___ No High Blood Pressure
___ Yes ___ No HIV-Positive/AIDS
___ Yes ___ No Kidney Disease
___ Yes ___ No Low Blood Pressure
___ Yes ___ No Radiation Treatment
___ Yes ___ No Respiratory Disease
___ Yes ___ No Sinus Problems
___ Yes ___ No Stroke
___ Yes ___ No Thyroid Problems
___ Yes ___ No Tuberculosis/Lung Disease

___ Yes ___ No Artificial Heart Valves
___ Yes ___ No Artificial Joints, Screws, Pins
___ Yes ___ No Congenital Heart Defect
___ Yes ___ No Heart Murmur
___ Yes ___ No Mitral Valve Prolapse
___ Yes ___ No Rheumatic Fever
___ Yes ___ No Have you taken "fen-phen" for weight loss?

Are you allergic to or had an adverse reaction to:
___ Yes ___ No Codeine/Hydrocodone
___ Yes ___ No Latex
___ Yes ___ No Local Anesthetics
___ Yes ___ No Penicillin/Amoxicillin
___ Yes ___ No Other Drugs Allergies:
_____

Medications you are currently taking:
___ Yes ___ No Antibiotics
___ Yes ___ No Aspirin
___ Yes ___ No Blood Thinner

Please list all medications below:
_____
_____
_____
_____
_____

Any other medical conditions we should know about:
_____
_____

Do you use tobacco? ___ Yes ___ No Type? _____ How much? _____ How long? _____
(Women) Are you pregnant? ___ Yes ___ No Due date: _____ Are you nursing? ___ Yes ___ No

Reason for today's visit: _____ Date of last dental visit: _____

To the best of my knowledge, the information provided on this form is complete and accurate. I understand that it is my responsibility to inform the doctor if there are any changes in my health in the future.
I give my consent to perform necessary dental services for myself or my child including x-rays, administration of anesthetics and medications.
I understand that I may be charged for a broken appointment if I fail to notify the office within 24 hours.
I understand that my insurance claims will be filed for me, but that I am responsible for my deductible and co-pay on the day of service. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I hereby authorize my insurance company to assign payment directly to Dr. Laurie Deemer.

Signature of Patient (or Parent/Guardian): _____ Date: _____

Please indicate your preferred method of payment: ___ Cash ___ Check ___ Visa ___ Mastercard

We thank you for the trust you have placed in us. Please don't hesitate to discuss any questions or concerns that you may have with Dr. Laurie or any of the staff. We are here to serve you and we welcome you to our family of patients.