Blackburn & Blackburn, DDS

2812 Piedmont Rd. N.E
Atlanta, GA 30305
404-659-7696

Patient Information

Patient Name: ____ Date ___________
Last First MI

☐ Male ☐ Female Date of Birth ____________________

Social Security # _____________ Driver's License # _____________ State ________

Phone (Home): _______________ (Work): __________________ (Cell):_________

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name: _________________________ Occupation: ___________________

Address: ____
Street City Zip Code

Previous Dentist: _________________________ Date of Last Dental Visit: _________

Reason for visit ____

Medical/Dental Record

Have you ever had any of the following? Please check those that apply:

- ☐ Aids
- ☐ Allergies___________
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Cancer
- ☐ Cold Sores/Fever Blisters
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ H.I.V. Positive
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Latex Sensitivity
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Smoke/Chew Tobacco
- ☐ Stroke
- ☐ Penicillin Allergy
- ☐ Allergic/Adverse Reaction to Medication or any Substance Abuse
- ☐ Other

- Are you taking any medications (prescription or non-prescription)? ☐Yes ☐No
  If yes, please list ____

(TURN TO BACK)

- Are you under the care of a physician? ☐ Yes ☐ No
  - Name of Physician: ____________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date: ________________

Cosmetic Information

	Yes	No
• Are you interested in knowing the options available for a more beautiful smile?	☐	☐
• Do you like the appearance of your teeth?	☐	☐
• Do you have any old fillings or dental treatment that you are unhappy with?	☐	☐
• Would you like any of your missing teeth replaced?	☐	☐
• Whom may we thank for referring you to our practice?	☐	☐

☐ Another patient, friend ☐ Another Doctor ☐ Dental Office
- Name of the person or office that referred you to our practice:

____

Method of Payment

☐ Cash ☐ Check ☐ Visa ☐ Master Card ☐ Veteran's Administration

☐ Medicaid# __________ Head of Card __________ Screening Date __________

☐ Insurance Company______________Insured person __________ ID# ________

☐ Other, Explain____

Consent for Services

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ________________