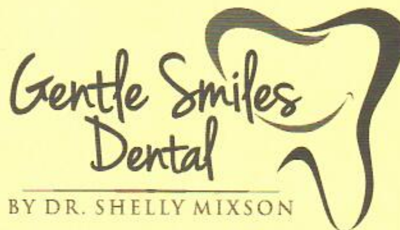

3528 Ashford Dunwoody Rd., Atlanta, GA 30319
Office: 770.455.6602 • Fax: 470.223.4851 • www.shellymixsondentist.com

PATIENT INFORMATION

____
Last Name First Name Initial

Patient Social Security #__________ Occupation ______________

Age _____ Birth Date ______________ Male _____ Female _____

Street Address ______________________________

City ______________________ State ____ Zip ________

Single ____ Married ____ Widowed ____ Divorced ____ Separated

Home Phone ________________ Work Phone ______________

DENTAL INSURANCE

____
Last Name First Name Initial

Relationship To Patient ______________________________

Home Phone ________________ Work Phone ______________

Birth Date ____________ Social Security # ________________

Responsible Party Employed By ______________________________

Insurance Company ______________________________

Subscribe ID Group # ______________________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

Direct Mail _________ Drive By _________ Internet _________ Referred By Another Dentist/Person ______________________

Are You In Good Health? ______________________________

Have There Been Any Changes In Your Health Within The Past Year? ______________________________

Your Last Physical Examination Was ______________________ The Name Of Your Physician Is ______________________

Are You Taking Any Drugs Or Medications? ______________________________

Have You Ever Had (Please Circle Yes or No)

Condition			Condition			Condition		
Angina	Yes	No	Aids/HIV Positive	Yes	No	Bleeding Disorders	Yes	No
Ulcers	Yes	No	High Blood Pressure	Yes	No	Problems With Kidneys	Yes	No
Colitis	Yes	No	Hepatitis	Yes	No	Heart Murmur	Yes	No
Tuberculosis	Yes	No	Parkinson's	Yes	No	Asthma	Yes	No
Emphysema	Yes	No	Alzheimer's	Yes	No	Cancer	Yes	No
Depression	Yes	No	Epilepsy	Yes	No	Radiation chemotherapy	Yes	No
Anxiety Disorders	Yes	No	Nervousness	Yes	No	Damage Heart Valves	Yes	No
Artificial Valves	Yes	No	Dizziness/Fainting	Yes	No	Thyroid Problems	Yes	No
Poor Circulation	Yes	No	History Of Heart Attack	Yes	No	History Of Blood Transfusion	Yes	No
Stroke	Yes	No	Difficulty Breathing	Yes	No	Are You Taking Blood Thinners	Yes	No
Diabetes	Yes	No	Are You Pregnant	Yes	No	Are You Breast Feeding	Yes	No
			Mitral Valve Prolapse	Yes	No	History Of Rheumatic Fever	Yes	No

Are You Allergic Or Have You Had A Reaction To:

A. Local Anesthetics	Yes	No	D. Aspirin	Yes	No
B. Penicillin Other Antibiotic	Yes	No	E. Iodine	Yes	No
C. Barbiturates	Yes	No	F. Latex	Yes	No
			G. Codeine	Yes	No

Do You Have Any Disease, Condition, Or Problem Not Listed About That We Should Know About?

If So, Please Explain: ______________________________

____

____

List Of Meds: ______________________________

____

____

DENTAL HISTORY

1. When was your last visit to the dentist? ____________________

2. Name of doctor's practice ____________________

3. Did you need treatment? ____ YES ____ NO

4. Have you ever had a negative experience at the dental office? ____ YES ____ NO

5. Explain (briefly) if you answered 'Yes' to question 5. ____________________

____

6. Are you happy with your smile? ____ YES ____ NO

7. Would you be interested in cosmetic dentistry? (Bleaching, Veneers, New Crowns, Orthodontics) __ YES ___ NO

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay Dr. Mixson all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Miscon to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

To the best of my knowledge, all information provided above is true. I understand and accept my responsibility to pay for all professional services that are provided.

____________________ ____________

Signature of Patient or Legal Guardian Date

Shelly Mixson DMD
3528 Ashford Dunwoody Rd., Atlanta, GA 30319

Acknowledgment of Receipt of Health Insurance Portability and Accountability Act (HIPAA) of 1996

I, ____________________ have received a copy of HIPAA of 1996.

____________________ ____________

Signature Date