Tara A. Fogle, DMD
Eric P. Swinson, DMD, PC
Jacqueline Delash, DMD

Welcome To Our Office

98 North Park Drive
Fayetteville, GA 30214
(770) 461-1141

Date _____

Patient's Soc. Sec. No. _____

Name _____ DOB _____ Age _____ Sex _____

Address _____ Home Phone _____

_____ Work Phone _____

E-mail for Appt. Reminder _____ Cell Phone _____

Employer _____ Position _____

Spouse (Parent if Minor) _____ DOB _____

Spouse's Employer _____ Position _____

Primary dental insurance company _____

Secondary dental insurance company _____

Name of Person responsible for fees _____

How did you learn of our office? _____

Name of person we may thank for referring you to us _____

Which dentist do you prefer to see? Dr. Fogle Dr. Swinson Dr. Delash No Preference

MEDICAL HISTORY

Physician's Name _____ Physician's Phone # _____

Physician's Address _____

List medications taking currently _____

Any allergy or reaction to: Drug _____Latex _____

Have you had any of the following? (circle Yes or No beside *each* problem or disorder)

Yes	No	anemia	Yes	No	excessive bleeding	Yes	No	nervous problems
Yes	No	any autoimmune disease	Yes	No	excessive radiation	Yes	No	osteoporosis
Yes	No	any venereal disease	Yes	No	heart problems	Yes	No	reaction to novocaine
Yes	No	arthritis	Yes	No	hepatitis	Yes	No	sinus problems
Yes	No	asthma	Yes	No	high blood pressure	Yes	No	stroke
Yes	No	cancer	Yes	No	jaundice	Yes	No	tuberculosis
Yes	No	circulatory problems	Yes	No	joint replacement	Yes	No	ulcer
Yes	No	diabetes	Yes	No	low blood pressure	Yes	No	Valve disorder

Have you ever taken bisphosphonates (Fosamax, Boniva) in the past year? Yes No

Describe any other condition, treatment, etc. _____

_____

Do you use tobacco? _____ If yes, form (e.g. cigarettes, chewing) _____

Do you regularly consume (circle) sweet tea, coffee, sodas, candy, cough drops?

TURN PAGE, PLEASE ⇨

DENTAL HISTORY

Name of previous dentist _____ Location _____

Have you had X-rays made in the last six months? _____

How often do you visit the dentist? _____

How often do you brush your teeth? _____ Floss? _____

Have you ever had any gum treatment? _____

Do you clench or grind your teeth? _____ When? _____

Do you have difficulty with dry mouth? _____

Are you having any present difficulties with your teeth? _____

Please describe: _____

What would make dental visits more pleasant?_____

_____

Does the appearance of your teeth concern you? _____

Is there anything you would like to change about your smile? _____

Please describe (color, shape, etc.) _____

_____

Any additional comments? _____

_____

I certify that the information on this form is correct. I will notify this office of any change in the information above.

Fees are due when services are rendered. With pre-approved insurance claims, you need to pay only the portion that your primary carrier does not cover. Past due accounts are subject to a monthly service charge. For your convenience, we accept Visa, MasterCard, American Express, Discover, and Care Credit. I acknowledge full responsibility for the payment of all fees incurred for services rendered to this patient.

Signed _____

FOR OFFICE USE ONLY

I certify that the information on this form is correct. I will notify this office of any change in the information provided.

Print Name: _____

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____