

Kirstin J. Risse, D.M.D., P.C.

Winston W. Lee, D.D.S., M.S.

6270 Smithpointe Drive
Norcross, Georgia 30092

Welcome To Our Office

Patient Information

Date _____

Name _____

Address _____

Home Phone _____

Work Phone _____

Birthday ___/___/___ age _____

— Married — Single — Divorce — Widowed

Name of spouse _____

Responsible Party

Name _____

Home Address _____

Home Phone _____

Business Phone _____

Occupation _____

Employer _____

Address _____

Phone _____

Are other members of your family patients in our office? _____

Referred to us by: _____

Emergency contact person _____ Phone _____

Insurance Information

Employer name _____

Employer address _____

Employer Phone number (with area code) _____

Employee Social Security number _____ - _____ - _____

Primary Insurance Company _____

Complete address of Insurance Company _____

Phone number of Insurance Company (with area code) _____

Group # _____

Please list any other family members on this insurance policy _____

Please be sure to answer questions on your health history on the other side of this form.

Health History

	Yes	No																												
1. Do you have pain from any area of your mouth?	___	___																												
2. Are you in good health?	___	___																												
3. When was your last physical examination? _____																														
4. Are you now under the care of a physician?	___	___																												
Physician's Name _____																														
Address _____ Phone # _____																														
5. Have you been hospitalized or had a serious illness within the past 5 years?	___	___																												
6. Are you now taking any medication, drugs or pills?	___	___																												
If yes, please list those drugs: _____																														

7. Are you allergic or have you reacted adversely to any of the following medications: (Please circle, if yes.)	___	___																												
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8. Are you aware of being allergic to any other medication or substance?	___	___																												
If yes, please list: _____																														
9. Have you ever had: (Please circle, if yes.)																														
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10. Do you get up often at night to urinate?	___	___																												
11. Are you thirsty much of the time?	___	___																												
12. Has anyone in your family had diabetes?	___	___																												
13. Do you consider yourself a nervous person?	___	___																												
14. Do you smoke? ___ Yes ___ No If yes, How much? _____																														
15. Do you have any disease, condition or problem not listed above that you think we should know about?	___	___																												
If yes, explain _____																														

For Women Only

Are you pregnant? ___ Yes ___ No If yes, what month? _____. Are you taking birth control pills? ___ Yes ___ No

Method of Payment

1. VISA
 2. MASTERCARD
 3. CASH OR CHECK

We will be happy to file your insurance for you as a courtesy. Any deductible or percentage the patient is responsible for is expected at the time of service.

Consent

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anaesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If insurance is provided, patient's share is due at time of service. All accounts 60 days and over will be assessed a 1.5% service charge on the unpaid balance, not to exceed 18% per annum. If your account balance is not paid, you may be responsible for the cost of collection which includes court costs and reasonable attorney fees and/or any other collection fees. It is the responsibility of the patient to insure that his/her insurance company makes prompt payment. I have read and understand this statement.

Date _____ Signature _____

Relationship to Patient _____