M. James Fagan, III, M.S., D.M.D, LLC *404-255-5006*
The Medical Quarters - Suite140
5555 Peachtree-Dunwoody Road NE
Atlanta, Georgia 30342

Welcome **- Our goal is to help you maintain excellent oral health. Please fill out these forms completely so that we may better serve your dental needs.**

Today's Date:_____ Social Security #:_____
Name:_____ Birthdate:_____ Age:_____ Sex:_____
Marital status: (circle) Single Married Widowed Divorced
Home Address: _____

City State Zip

Home #:_____ Work #:_____
Cell phone#:_____ Other #: _____
Business Name:_____ Occupation_____
Business Address : _____

City State Zip

E-mail address: _____
Emergency Contact_____ Phone#_____

Insurance coverage

Do you have Dental Insurance (if so please provide the following information)? Yes No
Insurance Company Name:_____ Phone#: _____
Policy ID#:_____ Policy Holders Name: _____
Policy Holders Date of Birth:_____ Policy holders Employer: _____

Person responsible for this account if patient is under the age of 18.
Name:_____ Birth date: _____
SSN_____ Contact#_____

If you are completing this form for the patient, what is your name, and your relationship to the patient? _____
Who is responsible for this account? _____
Name of your former/present dentist? _____
How will you be paying for your dental services: (please circle) Check Credit Card Cash
Other(i.e. financing)_____
Whom may we THANK for referring you? Internet Phone Book Real pages online
Other_____

Dental History

The following information is for our records only and is considered confidential. Please answer with thoughtful care so that I may be able to effectively diagnose your condition:

What is the nature of today's visit? _____

_____

1. Do you go to the dentist regularly? _____
2. When was your last dental exam?_____teeth cleaning?_____
3. Known date of last dental x-rays? _____
4. Have you ever been given professional instructions on home care? _____
5. Do you eat much candy, mints, drink soft drinks, or chew gum? _____
6. Have you ever had permanent teeth removed? _____
7. How many times a day do you brush your teeth? _____
8. Are your teeth sensitive to heat, cold, or sweets? _____
9. Does food catch between your teeth? _____
10. Do you clench or grind your teeth during the day? Yes No
11. Have you been made aware of clenching or grinding your teeth at night? Yes No
12. Do you ever wake up with your jaw clenched, or do you ever feel like you have slept with your jaw clenched all night? Yes No
13. Do you have a clicking or popping of your jaw joint? Yes No
14. Have you ever experienced the inability to open your mouth widely? Yes No
15. Which side do you chew on? Right_____Left_____Both_____
16. Do any members of your immediate family wear dentures? Yes No
If so, who? _____
17. If you wear dentures, do they give you problems? Yes No
If yes, circle all that apply: Pain Ill-Fitting Appearance Function
18. If you wear dentures, how old is your current set of teeth? _____
19. Do you want to keep your natural teeth for the rest of your life? Yes No
20. Are you currently experiencing discomfort/pain? Yes No
21. Do you have any difficulty swallowing? Yes No
22. Do you gums bleed when brushing your teeth? Yes No
23. Is any part of your mouth sensitive to temperature or pressure? Yes No
Please explain: _____
24. Have you ever been told you have pyorhhea? Yes No
26. Have you ever had orthodontic treatment? Yes No

Medical History

27. Has there been any change in your general health over the last year? _____
28. When was your last medical exam? _____
29. Are you currently under the care of a physician?_____If so, please explain

_____
30. The name and address of my physician is: _____
31. Have you had a serious illness within the past four years? _____

32. Do you have, or have you ever had any of the following diseases or problems?

a. Rheumatic Fever or Rheumatic Heart Disease	Yes	No
b. Congenital Heart Lesions	Yes	No
bb. Heart Murmur	Yes	No
c. Cardiovascular Disease (heart trouble, heart attack)	Yes	No
d. Pain In Your Chest Upon Exertion	Yes	No
e. Are You Ever Short Of Breath After Mild Exercise	Yes	No
f. Do your ankles swell	Yes	No
g. Do you ever get short of breath when you lie down	Yes	No
i. Sinus trouble	Yes	No
j. Asthma or hay fever	Yes	No
k. Hives or skin rash	Yes	No
l. Fainting spells or seizures	Yes	No
m. Diabetes	Yes	No
n. Hepatitis, Jaundice, or Liver Disease	Yes	No
o. Arthritis	Yes	No
p. Inflammatory Rheumatism	Yes	No
q. Stomach Ulcers	Yes	No
r. Kidney Trouble	Yes	No
s. Tuberculosis	Yes	No
t. Do you have a persistent cough or cough up blood	Yes	No
u. Low Blood Pressure	Yes	No
v. High Blood Pressure	Yes	No
w. Venereal Disease	Yes	No
x. AIDS	Yes	No
y. Are you taking Fosamax or a similar medication for bone density?	Yes	No
z. Do you smoke? If, yes how much per day?	Yes	No
aa. Abnormal Bleeding associated with surgeries?	Yes	No
bb. Do you bruise easily?	Yes	No
cc. blood transfusion?	Yes	No
dd. Anemia or any other blood disorder?	Yes	No
ee. surgery or x-ray treatment for a tumor, growth	Yes	No
ff. Psychiatric treatment	Yes	No

Other:_____

33. A. Are you currently taking any drugs or medicine? **Yes** **No**

If yes, please list _____

_____

B. Are you allergic to any medications? **Yes** **No**

If yes, please list_____

_____

34. Have you ever had any serious trouble associated with any previous Dental treatment? **Yes** **No**

If yes, please describe:_____

_____

FOR WOMEN ONLY:	**Are you pregnant?**	**Yes**	**No**
	Are you taking hormones?	**Yes**	**No**
	Are you taking birth control?	**Yes**	**No**
	Have you had a hysterectomy?	**Yes**	**No**

Signature_____**Date**_____

Please try to answer the following questions as thoroughly as possible. Thank you!

1. **List your chief complaints in the order of severity:**

2. **What is there about your present teeth that you do not like?**

3. **What would you like me to do for you?**

4. **Do you have any other questions or comments?**

Thank you for taking the time to complete this medical and dental questionnaire. I understand that it is very lengthy, but it will enable me to diagnose your case more completely and give you excellent treatment.

Patient Signature_____ Date_____

Doctor Signature_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS & CO-PAYMENT POLICIES

1.) We agree to accept assignment for the dental services provided to you. This means your insurance company's benefits check will be sent to Dr. Fagan. The process of insurance reimbursement to Dr. Fagan can take three to six weeks or more. Our acceptance of your insurance benefits is a free service we have elected to provide to you to help you spread out your financial burden for the dental services that you need for good dental health. In order for us to provide you with this free service, we ask that you promptly pay any remaining balance upon receipt of your statement from our office.

Patient initials_____

2.) In order to accept your dental insurance, we require you to make a co-payment on the estimated amount that your insurance company will not cover on each of your visits such as deductibles, co-pays or not covered procedures. We determine this amount based on our verification of your insurance benefit policy. It is impossible for us to know exactly what your insurance company will pay nor will they give us an exact amount of payment. Therefore, there may be an amount you owe or that we owe you after all the claims on your account are satisfied. If we have an adequate amount of time before starting dental services costing over $300.00, we will submit a pre-treatment estimate which will enable us to know approximately what coverage to expect from your carrier. This, too, can take 4-6 weeks or more.

Patient initials_____

3.) Some insurance companies insist on sending benefits checks the insured person even though the benefits are assigned to Dr. Fagan. In the event that your company sends an insurance check to you in error we expect for the check or checks to be signed over and mailed to Dr. Fagan upon receipt of the check. This will keep your account in good standing and enable us to continue to provide you with your necessary dental care.

Patient initials_____

4.) We will turn all delinquent accounts over to a collection agency if you do not pay or make payments on any remaining balances. You will be given adequate time and notice before this happens. These policies are, unfortunately, necessary to offset our spiraling health care costs.

Your signature below indicates that you have read and understand the payment policies listed and agree that you are responsible for any amounts insurance does not pay on your account.

Print Name_____

Signature_____Date_____

Thank you for your cooperation.

Rebecca White

Office Coordinator

Note: For any questions about our policies, please don't hesitate to speak with Anita Newsom.

Our address and phone # is as follows:

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