**NU-SMILE FAMILY DENTISTRY**
**1657 RIVER STREET**
**VALDOSTA, GA 31601 229-244-8884**

**DATE:_____**

**PATIENT NAME: _____ SS#_____ DL#_____**

**ADDRESS: _____CITY_____STATE_____ZIP_____**

**EMAIL ADDRESS: _____**

**HOME PHONE_____CELL_____WORK_____**

**BIRTHDATE_____FEMALE/MALE MARRIED/SINGLE/DIVORCED**

**EMPLOYER_____**

## DENTAL INSURANCE INFORMATION

**INSURANCE COMPANY_____**

**NAME OF INSURED_____RELATIONSHIP TO PT _____**

**DATE OF BIRTH/INSURED_____SS#_____**

**EMPLOYER_____**

**NOTE: PLEASE GIVE CARD TO FRONT DESK TO MAKE PHOTOCOPY**

### DENTAL HISTORY

**LAST DENTAL VISIT _____**

**REASON FOR TODAY'S VISIT_____**

**WHAT ARE YOUR DENTAL CONCERNS _____**

### MEDICAL HISTORY

**PHYSICIAN NAME_____DATE OF LAST VISIT_____**

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING_____**

**_____**

**ALLERGIES KNOWN_____**

**PREGNANT? YES/NO_NURSING? YES/NO __BIRTH CONTROL? YES/NO_**

**CIRCLE BELOW ANY THAT APPLY**

**AIDS**
**ARTIFICIAL HEART VALVE**
**ARTIFICIAL JOINTS**
**ARTHRITIS**
**ASTHMA**
**BLOOD DISEASE**
**CANCER**
**CHEMOTHERAPY**
**DIABETES**
**EPILEPSY**
**EYE DISEASE**
**GLAUCOMA**
**HEART DISEASE**
**HEART MURMUR**
**HEMOPHILIA**
**HEPATITUS**
**HIGH BLOOD PRESSURE**
**IMPLANTS/TRANSPLANTS**
**LATEX ALLERGY**
**MVP**
**MALARIA**
**MENINGITIS**
**MULTIPLE SCLEROSIS**
**MUSCULAR DYSTROPHY**
**PACEMAKER**
**PSYCHIATRIC CARE**
**RADIATION TREATMENT**
**RESPIATORY DISEASE**
**RHEUMATIC FEVER**
**SCARLET FEVER**
**SICKLE CELL DISEASE**
**STEROIDS**
**STROKE**
**SURGICAL STENTS**
**THYROID DISEASE**
**TOBACCO HABIT**
**TUBERULOSIS**
**ULCERS**

## CONSENT FOR TREATMENT

**TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH. I GIVE CONSENT FOR ME OR MY CHILD TO HAVE DENTAL TREATMENT PERFORMED BY DR. SHERRY COLVIN AND HER STAFF. I UNDERSTAND THERE ARE RISKS INVOLVED WITH THE ADMINISTRATION OF LOCAL ANESTHETICS, MEDICINES, AND WITH CERTAIN DENTAL PROCEDURES.**

**SIGNATURE PATIENT/PARENT/GUARDIAN DATE**

**PLEASE PRINT _____**

**APPOINTMENTS**

**JUST AS IF A HOTEL RESERVES A ROOM FOR YOU, WE RESERVE A TREATMENT SUITE FOR YOU. WE RESERVE THE DOCTORS AND ASSISTANTS TIME JUST FOR YOUR TREATMENT. IF FOR ANY REASON YOU HAVE TO CHANGE YOUR APPOOINTMENT, WE ASK THAT YOU GIVE OUR OFFICE A (48) HOUR NOTICE. OTHERWISE, THERE WILL BE A $50.00 CHARGE INCURRED FOR A "MISSED/BROKEN" APPOITNMENT. THIS WILL BE DUE PRIOR TO BEING SEATED AT YOUR NEXT VISIT.**

**INSURANCE**

**I CERTIFY THAT I AND/OR MY DEPENDENTS HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. COLVIN ALL INSURANCE BENEFITS, IF ANY, OTHERWISE, PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.**

**THE ABOVE NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.**

**REFUNDS**

**It is the policy of this office, that once a patient has entered into agreement of treatment and monies have been applied, that there is no refund to be made. If for whatever reason, the patient decides to discontinue treatment, any monies that have been paid to Nu-Smile Family Dentistry will remain here on the account. You can however, use any credited monies that is remaining on your account for an immediate family member. (This is only if they are a listed dependent on your account here with us). These credit balances will remain on the account for a total of (6) months. If the credit has not been used within this allotted time, the credit will no longer be valid and the account will reflect a zero balance.**

**I _____(patient or guardian) have read and fully understand the policies of this establishment and agree to all of them without question.**

**_____ DATE _____**
**SIGNATURE OF PATIENT/PARENT/GUARDIAN**

**_____**
**PLEASE PRINT NAME OF PATIENT/PARENT/GUARDIAN**