Member
ADA
American Dental Association®

Parsons Pointe
DENTAL CARE

Thomas J. Mazzuckelli PhD, DMD
11255 Parsons Road, Suite 100
Johns Creek, GA 30097

Registration Information:

Today's Date: _____

Patient's Name_____ Birth Date: _____

Name you preferred to be called: _____ SS#_____

Street Address: _____

City: _____ State & Zip Code: _____

Contact Information:

Cell Number: _____ Home Number: _____

Work Number: _____ Email Address: _____

Emergency Contact Name: _____ Contact Number: _____

If Child, Parent's Name: _____

How did you hear about our office? _____

Why have you come to our office? If you have a specific problem, please describe the nature of the problem.

_____

_____

_____

_____

_____

_____

Dental History

Do you have any concerns, or are you anxious about receiving dental treatment? ☐ Yes ☐ No

If yes, please tell what makes you anxious: _____

Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Brushing?

Have you had orthodontic treatment (braces)? If so, please tell us when treatment was started_____
And when it was completed: _____.

How often do you floss your teeth? ☐ Once a day ☐ Once a week ☐ Once a month

Do you experience any pain or discomfort from the joints of your jaw when you open wide, chew, or talk? ☐ Yes ☐ No

Do your jaws pop, click, or grate? ☐ Yes ☐ No

Do your gums bleed upon brushing and flossing? ☐ Yes ☐ No

Do you occasionally develop ulcers inside your mouth? ☐ Yes ☐ No

Do you develop cold sore on your lips? ☐ Yes ☐ No

Medical History

Your medical history is important. The information you provide will be held in confidence and will not be released without your consent.

Physician's name: _____

Are you currently taking any medications? ☐ Yes ☐ No

Please list names, the amount and frequency: _____

Are you allergic to any medication?
Please list: _____

Are you currently pregnant? (Females) ☐ Yes ☐ No

Do you have difficulties with excessive bleeding or any blood disorder? ☐ Yes ☐ No
Please describe the circumstances: _____

Have you been told in the past two years that you need medication prior to dental work? ☐ Yes ☐ No

Have you ever had any of the following?

☐ Cardiac Surgery ☐ Prosthetic Joint or Joint Replacement Surgery ☐ Diabetes ☐ Scarlet Fever

☐ Hepatitis ☐ Rheumatic Fever ☐ Hypertension ☐ Stroke

If so, please provide date of treatment: _____

Insurance Information:

Do you have any insurance which may help you pay for your dental treatment? ☐ Yes ☐ No

If yes, please provide the following information:

Insured's Name: _____ Insured's Employer: _____

Insured's S.S. #:_____ Insured's D.O.B.:_____

Name of Employer: _____ Employer's Telephone: _____

Insurance Company & Address: _____

_____

_____

Insurance Company Telephone: _____ Group Number: _____

Payment is expected as services are rendered unless prior financial arrangements have been made. Filing insurance claims is a service provided without charge although you are still responsible for charges incurred.

Signature: _____ Date: _____