Candler Dental Associates

Welcome! Thank you for selecting our dental team!

To help us better serve you, please fill out this form for us. Thank you for your cooperation.

Leon G Pye, DMD

About You

Today's Date_____

Name: _____ Preferred Name:_____ Date of Birth: _____
Last First Mi
S.S. #: _____-_____-_____ Male___ Female ___ Marital Status: Minor___ Single___ Married___
Home Address: _____ City: _____ State: ___ Zip: _____
Employer: _____ Current Occupation: _____
How did you hear about our office? _____

Contact Information

Mobile # _____ Home #: _____ Work #: _____ Ext:: _____
Pager #: _____ Email: _____ Fax #:_____
In case of emergency who should be notified? Name: _____ Phone #:_____
** Candler Dental Associates sends reminders via email/text messaging before each reserved appointment unless otherwise advised **

Financially Responsible Individual

Name: _____ Relationship to Patient: _____
Date of Birth: _____ S.S. #: _____-_____-_____ Driver's License #: _____
Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Information

Do you have dental coverage? Yes __ No __ (If no, please skip to the next section.) Insurance Company: _____
Insurance Company Address: _____ City: _____ State: _____ Zip: _____
Insurance Company Phone #: _____Policy Holder's Name: _____
Policy Holder 's S.S. #: _____-_____-_____ Policy Holder's Date of Birth: _____
Policy Holder's Employer: _____ Group #: _____ Relationship to Patient: _____
** If your insurance coverage changes, please call the office prior to future appointments**

Dental History

Do you wake up with soreness to your jaws?_____

Date of last dental visit? _____ Date of last full mouth x-rays? _____

Have you ever had gum disease therapy or deep cleaning? Yes __ No ____

How many times do you brush daily? _____ Floss? _____

Do your gums bleed when brushing? Yes __ No ___

What type of toothpaste do you use? _____ Would you be interested in teeth whitening? Yes __ No ___

Are you deeply concerned about the finances required to return your mouth to excellent

Do you suffer from bad breath? Yes __ No ___ dental health? __ Yes __ No ___

Are you in any type of dental pain? Yes __ No ___

Are any of your teeth sensitive? Yes ___ No ___ To what (i.e. hot, cold)? _____

Do you grind or clench your teeth? Yes __ No ____

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Medical History

Primary Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? No ___ Yes ___ If yes, describe _____

Has a doctor told you that you need antibiotics to premedicate for dental work? No ___ Yes ___
Women: Are you pregnant? No __ Yes __ Are you nursing? No __ Yes __ Are you taking birth control pills? No __ Yes __

Please check all of the following you have had or have currently:

__Anemia	__Chemotherapy	__Glaucoma	__Kidney Disease	__Swelling (Feet/Ankles)
__Arthritis, Rheumatism	__Circulatory Problems	__Headaches	__Liver Disease	__Thyroid Problems
__Artificial Joints	__Cough, Persistent	__Heart Problems	__Pacemaker	__Tonsillitis
__Asthma	__Cough Up Blood	__Hemophilia	__Radiation	__Ulcer
__Back Problems	__Depression	__Hepatitis	__Rheumatic Fever	__Venereal Disease
__Blood Disease	__Diabetes	__High Blood Pressure	__Scarlet Fever	
__Cancer	__Epilepsy	__HIV/AIDS	__Shortness Of Breath	
__Chemical Dependency	__Fainting	__Jaw Pains	__Skin Rash	

Other: _____

Do you have any allergies: _____

Are you currently taking any medications? (If so, please include dosage) _____
_____
_____

Authorization and Release

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that I am financially responsible for all charges whether or not the charges are covered by insurance.** I authorize the release of any information, including the diagnosis and records of treatment examination rendered, to my insurance company and other healthcare providers as necessary.

Photograph Release

I hereby authorize Candler Dental Associates to take photographs of my face, jaws, and teeth. I understand that the photographs will be used to aid in determining proper diagnosis for future treatment options and also may be used for educational purposes.

Cancellation Policy

In our office, we believe in spending time to do the best job we can for our patients. We do not double-book the schedule, so that we can have ample time to spend with our patients. We ask that you give us a 1 business day notice if you need to cancel or change your appointment. If the cancellation or change is not done within the requested time frame, a **$50 charge will be posted to your account** to help offset the cost of the missed appointment. Please keep in mind that our business week is Monday thru Thursday. We intend to keep a more personalized approach to providing the highest quality of dentistry in a small environment.

Please Sign: I understand and agree to all of the above

X_____

Signature Today's Date