W. Emory Linder, Jr., D.D.S., P.A.
A. Scott Linder, D.M.D.
1060 Gaines School Road-Suite B
Athens, GA 30605
(706) 549-4244

Date _____ Date of Birth _____

Patient's Name _____

Circle one: single married separated divorced widowed

Mailing address _____

_____
city state zip

Patient's social security # _____

Home # _____ Work # _____

Cell # _____

Email _____

Patient's employer _____

Business address _____

Position _____ How long held _____

Spouse's name _____ Employer _____

Spouse's Position _____ How long held _____

Spouse's social security # _____

Referred by _____

Who will pay this account _____

Reason for appointment _____

I, the undersigned, certify that if I (or my dependents) have insurance coverage, I assign directly to Dr. Linder all benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Linder to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions. If I fail to pay when due all amounts owed, I agree to pay all costs of collections or attorney fees.

_____ _____
Responsible Party Signature Date

1. Are you having any pain or discomfort at this time?..... yes no
2. Do you feel very nervous about having dental treatment?..... yes no
3. Have you ever had a bad experience at the dentist?..... yes no
4. Have you been a patient in a hospital in the past 2 years?.....yes no
5. Have you been under the care of a physician in the past 2 years?..... yes no
6. Have you been on any medication/drugs during the past 2 years?..... yes no
7. Are you allergic to/made sick by penicillin, aspirin, codeine, or any other drugs or medications?..... yes no
8. Have you ever had any excessive bleeding requiring treatment?..... yes no

Circle any of the following which you have had or presently have:

Heart Failure	Emphysema	AIDs
Heart Disease/attack	Cough	Hepatitis A
Angina Pectoris	Tuberculosis (TB)	Hepatitis B
High Blood Pressure	Asthma	Hepatitis C
Heart Murmur	Hay fever	Liver Disease
Rheumatic Fever	Sinus Trouble	Jaundice
Congenital Heart Lesions	Allergies/Hives	Blood Transfusion
Scarlet Fever	Diabetes	Drug Addiction
Artificial Heart Valve	Thyroid Disease	Hemophilia
Heart Pacemaker	X ray/Cobalt Treatment	Venereal Disease
Heart Surgery	Mitral Valve Prolapse	Syphilis
Artificial Joint	Chemotherapy	Gonorrhea
Anemia	Cancer	Genital Herpes
Stroke	Arthritis	Epilepsy
Kidney Trouble	Rheumatism	Seizures
Ulcers	Pain in Jaw Joints	Fainting
Glaucoma	Cortisone Medicine	Dizzy Spells
HIV	Bruise Easily	Vertigo
Sickle Cell Disease	Psychiatric Treatment	Nervousness

10. When you walk up stairs or take a walk do you ever have to stop because of chest pain, fatigue, or shortness of breath?..... yes no
11. Do your ankles swell during the day?..... yes no
12. Do you use more than 2 pillows to sleep?..... yes no
13. Have you lost/gained more than 10 pounds in the last year?..... yes no
14. Do you ever wake up short of breath?..... yes no
15. Are you on a special diet?..... yes no
16. Has your medical doctor ever said you had cancer or a tumor?..... yes no
17. Do you have any disease, condition, or problem not listed?..... yes no
18. Women: are you pregnant now?..... yes no
19. Please list all medications you are currently taking:

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medications change, I will notify Dr. Linder at the next appointment.

Date:_____ Responsible Party Signature:_____

Patient Data Sheet

Patient's full name _____ **Birth date:** _____ **SSN:** ___-___-____
First middle initial last

Mailing address: _____
City zip

Home #: _____ **Cell #:** _____ **Work #:** _____

Referred by? _____ **Student Status (circle one):** N/A part time full time

Name of School: _____

Marital Status (circle one): single married separated divorced widowed

Employer: _____ **Position held:** _____

Employer Address: _____ **How long held?** _____

Responsible Party: _____ **circle one:** self parent guardian other

Social Security #: _____ **Employer:** _____

Employer's Address: _____
City zip

Position held: _____ **Work #:** _____

Spouse: _____ **Spouses employer:** _____

Spouses Work #: _____ **SSN:** ___-___-_____ **Position held:** _____

***Emergency Contact:** _____ **Phone #:** _____

Dental Insurance Information
Primary Coverage

Policy holder's full name: _____ **Birth date:** _____
First middle initial last

Policy Holder's address: _____

Policy Holder's Social Security #: _____ **Group ID #:** _____

Policyholder's Employer: _____

Relationship to Patient (circle one): self spouse guardian other: _____

Insurance Company: _____

Insurance Company's address: _____
City zip

Insurance Company's phone #: _____

Please let us make a copy of your insurance card. Thanks!

I, the undersigned, certify that if I (or my dependants) have insurance coverage, I assign directly to Dr. Linder all benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Linder to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions. If I fail to pay when due all amounts owed, I agree to pay all costs of collections or attorney fees.

Responsible party signature _____ date _____