

Marilyn S. Gaylor, D.D.S.

General Dentistry

Welcome to our dental family. We appreciate the confidence and trust you have placed in us and look forward to meeting you and learning to know you professionally and personally.

We will provide you with the highest quality of preventive and treatment dentistry that is “state of the art”. You will receive a complete, thorough examination gathering all pertinent information appropriate for your individual situation. I will review all the information, establishing a diagnosis and life-long care program that will assist you in maintaining your personal dental health.

Our mission and goal is for you to keep all of your teeth all of your life in maximum comfort, function, health, and esthetics. In reaching this goal in a realistic and appropriate manner, you will have the choice of options within that care program that will enable you to attain and maintain your dental health within your personal time frame. We will discuss your treatment needs and the related fees with you in a caring, but open manner, because we know you want all the information with regard to need, care, and investment.

Please complete all enclosed information sheets and bring them with you completed for your first appointment. If you have dental coverage, please bring your dental insurance card and all necessary information for filing. We will be glad to file your insurance to reimburse you, as we ask for payment at time of service.

We will make every effort to maintain our schedule with yours. Please assist us by calling *24 hours* in advance to reschedule an appointment. This office may assess a fee equal to the charge of the services that would have been rendered if proper notice is not given. We appreciate your understanding of our cancellation policy.

Individually and collectively we pledge to you ultimate effort and understanding in providing preventive dental health and education in combination with highest quality restorative care. We welcome any questions or concerns you may have.

Sincerely,

Marilyn S. Gaylor, D.D.S.
and Staff

(404) 351-8790

Northwest Medical Center – 3280 Howell Mill Road, N.W., Suite 335 – Atlanta, Ga 30327

PATIENT REGISTRATION

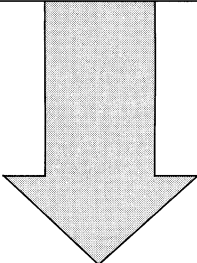
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name

DENTAL HISTORY

Patient Account No.

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

Date of Last Dental Visit Last Dental Cleaning Last Full Mouth X-rays

What was done at your last dental visit?

Previous Dentist's Name

Address State Zip

Telephone

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? Yes No

If yes, please describe:

Are any of your teeth sensitive to:

- Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No
Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
If yes, where?

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Snore or have any other sleeping disorders? Yes No
Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause

Have you experienced:

- Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance?

- Would you like to keep all of your teeth all of your life? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No
If yes, please describe

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe

(Please complete other side)

Marilyn S. Gaylor, D.D.S.

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DIRECTIONS TO OUR OFFICE

From I-285

Go to I-75 SOUTH TOWARD ATLANTA. TAKE EXIT 255 (West Paces Ferry Road/Northside Parkway)

AT BOTTOM OF EXIT, TAKE A LEFT. GO UNDER BRIDGE TO LIGHT.

TAKE A RIGHT ONTO NORTHSIDE PARKWAY. GO TO SECOND TRAFFIC LIGHT.

TAKE A RIGHT ONTO HOWELL MILL ROAD.

Northwest Medical Center is the first building on the right. Take the first right turn, which takes you between the medical center and the parking deck. Go left into the parking deck and enter through the front of the building (WEST WING ENTRANCE). The elevator is inside the doorway on the left. Go to the 3rd floor, we are in suite #335.

FROM I-75 GOING NORTH FROM ATLANTA:

Go to I-75 North and take the WEST PACES FERRY ROAD/NORTHSIDE PARKWAY EXIT.

TAKE A RIGHT AT THE LIGHT AT THE END OF THE EXIT.

GO TO THE NEXT LIGHT AND TAKE A RIGHT ON HOWELL MILL RD.

Northwest Medical Center is the first building on the right. Take the first right turn, which takes you between the medical center and the parking deck. Go left into the parking deck and enter through the front of the building (WEST WING ENTRANCE). The elevator is inside the doorway on the left. Go to the 3rd floor, we are in suite #335.

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