Stockbridge Dental

Dr. Christine E. Lee, DMD
350 Country Club Drive, Suite E
Stockbridge Georgia 30281

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____ Preferred method of contact: ❍Text ❍Email ❍Call

Emergency Contact: _____ Relation: _____ Phone #: _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last appointment? ❍ Yes ❍ No

If yes, please explain: _____

Are you taking any kind of medication at this time? ❍ Yes ❍ No

If yes, list each one: _____

Do you have any allergies to medications? ❍ Yes ❍ No

If yes, please explain: _____

Have you had any major health issues, surgeries, or hospitalizations since your last visit? ❍ Yes ❍ No

If yes, please explain: _____

Are you required to premedicate before dental procedures? ❍ Yes ❍ No

If yes, please explain: _____

Have you ever taken bisphosphonates, i.e. Fosamax? ❍ Yes ❍ No

If yes, please explain: _____

Women: Are you pregnant? ❍ Yes ❍ No Due Date: _____

DENTAL BENEFIT INFORMATION

Primary Ins. Company: _____ Secondary Ins. Company: _____

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

SS # or Member ID: _____ SS # or Member ID: _____

Policy#/Employer: _____ Policy#/Employer: _____

I certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold Stockrbidge Dental, LLC responsible for any errors or omissions that I have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Guardian if minor) Date Reviewed by Staff Date