

**Michael O Vernon D.M.D.  
D.M.D**

**Christopher M Moldovan**

**Augusta Dental Associates**  
1218 Augusta West Parkway  
Augusta, GA 30909

**Welcome** to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointments, or fees, please feel free to ask.

(Please Print) Today's Date: \_\_\_\_\_ Patients Date of Birth: \_\_\_\_\_

Name:

\_\_\_\_\_  
(Last) (First) (Preferred name) (Marital Status) (Spouse's Name)

Person responsible for payment of service rendered (guardian) \_\_\_\_\_

Residence Address: \_\_\_\_\_  
(City) (State) (Zip)

Email Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Social Security No: \_\_\_\_\_

Name of Business: \_\_\_\_\_ Position: \_\_\_\_\_

Business Address: \_\_\_\_\_  
(City) (State) (Zip)

**Insurance**  
**(PLEASE READ THOROUGHLY)**

As a courtesy to you, we can take assignment of your dental insurance benefits. To accurately file your claims, please present your dental insurance card and complete the following information.

**INFORMATION ABOUT THE PERSON WHO CARRIES THE DENTAL INSURANCE:** Name: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dental Insurance Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Policy or Union No: \_\_\_\_\_

Address to mail completed insurance claim: \_\_\_\_\_

**Your total balance charged and dental insurance is your financial responsibility, but we can help. If you wish for us to file your dental insurance, we must ask that you be prepared after each visit to pay the *ESTIMATED* amount that the insurance will not cover based on the information provided by your insurance company.**

I hereby authorize the release to and the use by  
Michael O. Vernon, D.M.D., P.C. any dental or other information needed  
in processing the claims resulting from treatment rendered in this office.

I hereby authorize the payment of dental benefits directly to  
Michael O. Vernon, D.M.D., P.C.  
Christopher M. Moldovan, D.M.D., P.C.

\_\_\_\_\_  
Signed (patient)

\_\_\_\_\_  
date

\_\_\_\_\_  
Signed (insured)

\_\_\_\_\_  
date

**PLEASE SEE OTHER SIDE**

**MICHAEL O. VERNON, D.M.D., P.C.  
CHRISTOPHER MOLDOVAN, D.M.D.  
1218 Augusta West Parkway  
AUGUSTA, GA 30909**

I understand that all fees incurred by my dependents or myself regardless of insurance coverage, is my responsibility and I will be liable for payment of these charges.

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Signature of Guarantor of Account

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Date

## MEDICAL HISTORY

- (1) How would you classify your General Health (circle one)?      **Excellent**    **Good**    **Fair**    **Poor**
- (2) Are you presently under the care of a physician? If yes, for what? \_\_\_\_\_
- (3) Personal Physician \_\_\_\_\_ Address/Phone \_\_\_\_\_

**Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment. PLEASE CHECK THE APPROPRIATE BOX for any conditions that you have now or had in the past.**  
(Parent/Guardian: Please check the appropriate boxes concerning your child's health status)

<b><u>Cardiovascular (Heart)</u></b>	<b>Yes</b>	<b>No</b>	<b><u>Nerves &amp; Sensory</u></b>	<b>Yes</b>	<b>No</b>	<b><u>Gastrointestinal (Stomach)</u></b>	<b>Yes</b>	<b>No</b>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
<i>If so When?</i> _____			Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<i>When?</i> _____		
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<i>If so, type?</i> _____		
Take Coumadin	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Take Daily Aspirin	<input type="checkbox"/>	<input type="checkbox"/>				Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Cardiac Valves	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Respiratory (Breathing)</u></b>			<b><u>Hematologic (Blood)</u></b>		
Previous Infective Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	<i>If so, when?</i> _____		
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<i>Use inhaler?</i> _____			Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>				HIV / AIDS Positive	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Dermal/Musculoskeletal</u></b>			<b><u>Urinary</u></b>		
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>
<i>If so, when?</i> _____			Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>			
Other Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sore Jaw Muscles / Joints	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Other Conditions</u></b>		
<i>What,</i> _____			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Use Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
			Mouth Ulcers / Sores	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Have you been instructed to premedicate with antibiotics prior to all dental treatment for any health related conditions (such as Artificial Valves, Artificial Joints, Previous Heart Infection, etc...)?			<b><u>Endocrine (Hormonal)</u></b>			Tumor / Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation / Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Take Insulin?</i> _____					
			Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever taken medication for **Osteoporosis/Bone Disease** to increase bone density (i.e. Fosamax, Boniva, Actonel, Aredia, Zometa, Reclast)    **Yes**     **No**

Are you taking (or supposed to be taking) any medicine, drugs or pills of any kind (including Aspirin / non-prescription drugs)?  
**Yes**     **No**     If so, what?

Are you allergic to any drugs or medicines (**Including anesthetic**)?    **Yes**     **No**     If so, what drug?/What type of reaction did you have?

Please list any other medical conditions or concerns not mentioned above that the Doctor should be aware of:

**WOMEN:** Are you pregnant?    **Yes**     **No**     How long (circle one)?    **1-3 months**    **3-6 months**    **6-9 months**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment.

\_\_\_\_\_ Date

\_\_\_\_\_ Patient, Parent or Guardian Signature

