Whitefoord, Inc.

Dental Clinics

Whitefoord Early Learning Academy (WELA)
35 Whitefoord Avenue

Whitefoord Family Medical Center
30 Warren Street, SE

King Middle School Clinic
565 Hill Street

Toomer Elementary
65 Rogers St NE, Atlanta, GA 30317

Please print the following information in blue or black ink

Name_____

Address_____

City_____State_____Zip Code_____

Home Number_____Mobile Phone_____

Birth Date_____Email Address_____

Social Security Number_____ Gender Male_____Female_____

Circle one:

African American**Caucasian Hispanic** Asian & Pacific Islander**Other_____

Financial Information

We offer discount based on a sliding fee scale, giving us your household information would help us determine if you qualify for our sliding fee scale discount:

Number of people in household_____ Estimate of household income_____

Insurance Company_____Policy Number_____Group Number_____

Person Responsible for Bill_____

Emergency Contact Name_____Number_____

Relationship_____

Preferred Pharmacy_____Location_____

Are you a smoker? Yes_____No_____

Are you interested in our tobacco cessation program? Yes_____No_____

Are you taking in medications? Yes_____No_____If so what_____

Are you allergic to any medications? If so what_____

Have you ever been hospitalized? Yes_____No_____If so what_____

	no	yes		no	yes
AIDS/HIV			Hepatitis		
Anemia			High Blood Pressure		
Asthma			Hormone Disorder		
Bleeding Tendency			Hyperactivity		
Blood Disorder			Jaundice		
Blood Transfusion			Kidney Disease		
Bone Disorder			Liver Disease		
Cancer			Mental Retardation		
Diabetes			Muscle Disorder		
Ear Disorder			Nose/Throat Disorder		
Epilepsy			Pregnant (presently)		
Eye Disorder			Prolonged Illness		
Fainting Spells			Rheumatic Fever		
Heart Condition			Skin Disorder		
Heart Murmur			Speech Problem		
Hemophilia			Stomach Problems		

Do you have any condition(s) that was not listed?_____

To the best of your knowledge are you healthy?_____

When was your last visit to the dentist?_____

How often do you brush your teeth?____Occasionally_____Once Daily_____Twice Daily_____

Have you had a toothache recently?_____Yes_____No

Have you had any injury to your teeth or jaws?_____

Do you suck your fingers or thumb?_____Yes_____No

Do you have any other dental condition that you are concerned about?_____

I authorize release of information from my dental record to the family doctor of primary care provider designated by me whenever necessary for my care including referrals, consultations and/or emergency services. I authorize that the information is correct and hereby authorize periodic dental examination including photographs, radiographs and other acceptable methods of the management of my dental health

Patient Name_____Patient Signature_____Date_____