

Welcome! Thank you for selecting our dental team! We always live by our mission:
"To provide the highest quality dental care in the most comfortable environment possible."
To help us better serve you, please fill out this form for us. Thank you for your cooperation.

Walter L. Leeks, III DMD

About You

Today's Date _____

Name: _____ Preferred Name: _____ Date of Birth: _____
Last First Mi
S.S. #: _____ - _____ - _____ Male ___ Female ___ Marital Status: Minor ___ Single ___ Married ___
Home Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Current Occupation: _____
How did you hear about our office? _____

Contact Information

Mobile # _____ Home #: _____ Work #: _____ Ext.: _____
Pager #: _____ Email: _____ Fax #: _____
In case of emergency who should be notified? Name: _____ Phone #: _____

** New Image Dentistry at Inman Park sends reminders via email/text messaging before each reserved appointment unless otherwise advised **

Financially Responsible Individual

Name: _____ Relationship to Patient: _____
Date of Birth: _____ S.S. #: _____ - _____ - _____ Driver's License #: _____
Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Information

Do you have dental coverage? Yes ___ No ___ (If no, please skip to the next section.) Insurance Company: _____
Insurance Company Address: _____ City: _____ State: _____ Zip: _____
Insurance Company Phone #: _____ Policy Holder's Name: _____
Policy Holder's S.S. #: _____ - _____ - _____ Policy Holder's Date of Birth: _____
Policy Holder's Employer: _____ Group #: _____ Relationship to Patient: _____

** If your insurance coverage changes, please call the office prior to future appointments**

Dental History

Previous Dentist: _____
Date of last dental visit? _____ Date of last full mouth x-rays? _____
How many times do you brush daily? _____ Floss? _____
Do you use an electric toothbrush? Yes ___ No ___ If yes, what type? _____
Do your gums bleed when brushing? Yes ___ No ___
What type of toothpaste do you use? _____
Do you use mouthwash? Yes ___ No ___ If yes, what type? _____
Do you suffer from bad breath? Yes ___ No ___
Are you in any type of dental pain? Yes ___ No ___
Are any of your teeth sensitive? Yes ___ No ___ To what (i.e. hot, cold)? _____
Do you grind or clench your teeth? Yes ___ No ___

Do you wake up with soreness to your jaws? _____
Have you ever had gum disease therapy or deep cleaning? Yes ___ No ___
If yes, please describe: _____
Would you be interested in cosmetically replacing older dark fillings with new tooth colored restorations? Yes ___ No ___
Would you be interested in teeth whitening? Yes ___ No ___
Are you deeply concerned about the finances required to return your mouth to excellent dental health? ___ Yes ___ No ___
If you had a magic wand and could change anything about your smile what would you change? _____

Medical History

Primary Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? No _____ Yes _____ If yes, describe _____

Has a doctor told you that you need antibiotics to premedicate for dental work? No _____ Yes _____

Women: Are you pregnant? No ___ Yes ___ Are you nursing? No ___ Yes ___ Are you taking birth control pills? No ___ Yes ___

Please check all of the following you have had or have currently:

- ___ Anemia ___ Chemotherapy ___ Glaucoma ___ Kidney Disease ___ Swelling (Feet/Ankles)
___ Arthritis, Rheumatism ___ Circulatory Problems ___ Headaches ___ Liver Disease ___ Thyroid Problems
___ Artificial Joints ___ Cough, Persistent ___ Heart Problems ___ Pacemaker ___ Tonsillitis
___ Asthma ___ Cough Up Blood ___ Hemophilia ___ Radiation ___ Ulcer
___ Back Problems ___ Depression ___ Hepatitis ___ Rheumatic Fever ___ Venereal Disease
___ Blood Disease ___ Diabetes ___ High Blood Pressure ___ Scarlet Fever
___ Cancer ___ Epilepsy ___ HIV/AIDS ___ Shortness Of Breath
___ Chemical Dependency ___ Fainting ___ Jaw Pains ___ Skin Rash

Do you have any allergies: _____

Are you currently taking any medications? (If so, please include dosage) _____

We offer these amenities to make your visit comfortable:

- Satellite Radio with headset Comfortable head, neck, back and knee supports
Soft blanket to keep you warm Warm face towels upon completion of treatment

What are your thoughts about your previous dental visit?

Was the treatment comfortable? Yes ___ No ___ Were the fees explained clearly prior to your appointment? Yes ___ No ___
Was the staff friendly? Yes ___ No ___ Was treatment explained to you prior to your appointment? Yes ___ No ___
Were you seen in a timely manner? Yes ___ No ___ Do you have any additional concerns: _____

Authorization and Release

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
I understand that I am financially responsible for all charges whether or not the charges are covered by insurance. I authorize the release of any information, including the diagnosis and records of treatment examination rendered, to my insurance company and other healthcare providers as necessary.

Photograph Release

I hereby authorize New Image Dentistry at Inman Park to take photographs of my face, jaws, and teeth.
I understand that the photographs will be used to aid in determining proper diagnosis for future treatment options and also may be used for educational purposes.

Cancellation Policy

In our office, we believe in spending time to do the best job we can for our patients. We do not double-book the schedule, so that we can have ample time to spend without patients. We ask that you give us a 2 business day notice if you need to cancel or change your appointment.
If the cancellation or change is not done within the requested time frame, a \$50 charge will be posted to your account to help offset the cost of the missed appointment. Please keep in mind that our business week is Monday thru Friday. We intend to keep a more personalized approach to providing the highest quality of dentistry in a small environment.

Please Sign: I understand and agree to all of the above

X _____ Signature Today's Date

Thank you for taking the time to assist us in getting to know your dental needs.
Walter L. Leeks, III DMD, PC