



GRAND DENTAL
ASSOCIATES
FARNSWORTH
DENTAL GROUP
CHANNAHON
FAMILY DENTISTRY

Hello!

The magic of a happy, healthy smile is immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Name _____

Today's Date _____

Driver's License # _____ Social Security # _____

about you

How did you hear about us? _____

Home Address _____ City _____ Zip _____

Mailing Address (if different from above) _____

Home Phone # _____ Work Phone # _____ Ext. _____

Mobile/Cell # _____ Pager # _____

E-mail Address _____

Your Employer _____

Employer's Address _____

Birthday _____ Male Female

Marital Status Single Married Divorced Widowed

dental insurance

MY DENTAL INSURANCE CO. _____ ID # _____

Group # _____ Phone # _____

Address _____

I have additional coverage through my Spouse Parent Other

Their Name: _____

Their Employer's Name _____

Their Birthdate _____

Their Dental Insurance Co. _____ ID # _____

Group # _____ Phone # _____

Address _____

emergency

IN THE EVENT OF AN EMERGENCY, WHO LIVES NEAR YOU THAT WE CAN CONTACT?

Name _____ Relationship _____

Work Phone # _____ Home Phone # _____ Cell Phone # _____

dental history

How can we help you today? _____

Are you in pain? Yes No If so, for how long? _____

The approximate date of your last dental visit _____

Name of previous dentist _____

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Do you grind your teeth? Yes No

Have you ever experienced TMJ problems (pain or discomfort in your jaw joints)? Yes No

Are you under any unusual stress at home or work? Yes No

medical history

Physician's Name _____ Phone # _____

The approximate date of your last doctor's visit _____

Your current physical health is Good Fair Poor

If you are currently under the care of any physician, please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Are you currently taking or have ever taken any bisphosphonate drugs (Fosamax/Alendronate, Boniva/Ibandronate, Actonel/Risedronate, Aredia/Pamidronate, Zometa/Zoledronate, etc.)? Yes No

If yes, please list drug name _____ Date(s) taken _____

If you are presently taking any other drugs prescribed by a physician or dentist, vitamins and/or herbal supplements, please list: _____

Do you need to take antibiotics or be pre-medicated before dental treatment? Yes No

Have you ever had any of the following diseases or medical problems? (please circle Yes or No)

| | | | | | | | | |
|---|---|------------------------------------|---|---|-------------------------------|---|---|----------------------|
| Y | N | Heart Attack/Disease/Stroke | Y | N | Cortisone Medication | Y | N | Sinus Problems |
| Y | N | Heart Murmur | Y | N | Hemophilia/ Abnormal Bleeding | Y | N | Fever Blisters |
| Y | N | Rheumatic Fever | Y | N | Asthma | Y | N | Arthritis |
| Y | N | Mitral Valve Prolapse | Y | N | Hepatitis A/B/C | Y | N | Tuberculosis (TB) |
| Y | N | Heart Surgery/Pacemaker | Y | N | Thyroid/Adrenal Disease | Y | N | Sickle Cell Disease |
| Y | N | Angina | Y | N | Cancer/Chemotherapy | Y | N | Joint Prosthesis |
| Y | N | Anemia | Y | N | HIV+/AIDS/ARC | Y | N | Glaucoma |
| Y | N | High/Low Blood Pressure | Y | N | Diabetes | Y | N | Psychiatric Problems |
| Y | N | Epilepsy/Seizures/ Fainting Spells | Y | N | Kidney Problems | Y | N | Drug/Alcohol Abuse |

If you have had any other medical problems, please explain _____

Are you allergic to any of the following drugs? (please circle Yes or No)

| | | | | | | | | | | | |
|---|---|--------------|---|---|--------------------|---|---|--------------|---|---|-------|
| Y | N | Penicillin | Y | N | Dental Anesthetics | Y | N | Tetracycline | Y | N | Latex |
| Y | N | Erythromycin | Y | N | Aspirin/Ibuprofen | Y | N | Codeine | | | |

Please list any other allergies _____

For women: Are you pregnant? No Yes, Week# _____

Are you taking birth-control pills? No Yes

IMPORTANT: I UNDERSTAND THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY PERSONAL INFORMATION, MEDICAL STATUS OR INSURANCE. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT. A FEE OF 1.5% WILL BE CHARGED TO ACCOUNTS 90 DAYS PAST DUE. IN THE EVENT OF COLLECTION ACTION, I AGREE TO PAY A THIRD OF THE OUTSTANDING BALANCE AS ATTORNEY'S FEES.

Signature _____ Date _____

(If under 18, guardian/account guarantor)