GRAND DENTAL Arts LLC

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www.GrandDentalArts.com

Patient Information

Name: _____ Today's Date _____
Address: _____ Date of Birth_____Age_____ Sex ____
City _____ State _____ Zip_____
Social Security # _____
Contact numbers (check where you would prefer we call or contact you)
☐Home_____☐Cell _____ ☐Work _____
Email _____
Would you like to receive correspondence/confirmation via email? ☐Yes / ☐ No
Occupation _____ Place of Employment _____

Do you have dental insurance? ☐Yes /☐No (*If yes, proceed to the next box. If no, skip the next box)*

Dental Insurance Information

Is the dental insurance in your name? ☐Yes /☐No

If yes, Insurance Company _____
ID#_____ Group #_____

If no, Insured's Name_____ Date of Birth _____
Employer _____
Insurance Company _____
ID#_____ Group #_____

Secondary Coverage?
If yes, Insured's Name _____Date of Birth_____
Employer_____
Insurance Company_____
ID#_____ Group #_____

In case of emergency, whom should we contact? _____
Home # _____ Cell #_____
Relationship_____

Referred to us by: _____

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Medical History (Please check all that apply)

Heart Problems
- ☐ Chest Pains
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Congenital heart lesions
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Heart Attack
- ☐ Anticoagulants (coumadin)
- ☐ Nitroglycerin or Digitalis

Blood Problems
- ☐ Easy Bruising
- ☐ Frequent Nose Bleeds
- ☐ Abnormal Bleeding
- ☐ Blood Disease
- ☐ Blood Transfusion

Bone/Joint Problems
- ☐ Arthritis/Rheumatism
- ☐ Back or Neck Pain
- ☐ Joint Replacement

Allergy Problems
- ☐ Hay Fever/Sinus problems
- ☐ Metal Allergy
- ☐ Asthma
- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin/Ibuprofen
- ☐ Codeine/Narcotics
- ☐ Latex
- ☐ Dental Anesthetic/Epinephrine
- ☐ Iodine
- ☐ Other _____

Women
- ☐ Pregnant
- ☐ Oral Contraceptives or Hormones

Other Medical Conditions
- ☐ Fainting/Seizures or Epilepsy
- ☐ Stroke
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Other Respiratory Disease
- ☐ Herpes
- ☐ Hepatitis, Jaundice, or Liver Trouble
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Kidney Disease
- ☐ Thyroid/Parathyroid Disorder
- ☐ Cancer/Tumor
- ☐ Emphysema
- ☐ Drink Alcohol
- ☐ Smoke/Chew Tobacco
- ☐ Ulcers
- ☐ Hearing trouble

Other issues not listed above:_____
_____

Physician's Name:_____
Phone:_____
Date of last physical exam _____
Are you in good health? ☐ Yes / ☐ No

Medications

Are you taking: ☐ Fosamax ☐ Actonel ☐ Aspirin daily ☐ Blood thinner ☐ Boniva ☐ Nitroglycerine

Please list medications you are currently taking: ☐ see attached ☐ **NONE Intials _____**

Name of Medication	Dose	Frequency	Condition/Reason
1.			
2.			
3.			
4.			
5.			

If additional space required, please attach list.

Has it been recommended for you to take antibiotics before dental treatment? ☐ Yes ☐ No

Have you been hospitalized or had a serious illness in the past five (5) years? ☐ Yes ☐ No
*If yes, please explain*_____
_____

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Dental History

What are your goals for the long term health of your teeth? _____
_____

If you had a magic wand and change anything about your smile, what would you change?
_____

Are you apprehensive about dental treatment or visiting the dental office? ☐Yes ☐No
*If yes, please explain*_____
_____

Have you had any serious trouble associated with any previous dental treatment? ☐Yes ☐No
*If yes, please explain*_____
_____

How can we make your visit more comfortable? _____
_____

Would you like your teeth: ☐Straightened? ☐Whitened? ☐Changed in Length or Shape?

Please check all that apply:

☐My jaw makes noise(s)
☐I experience pain in my jaw
☐I experience headaches or migraines
☐I experience tinnitis (ringing) in my ears
☐I experience vertigo (dizziness)
☐I have been told I grind my teeth
☐I have worn a retainer or night splint before
☐I "gag" easily
☐My teeth are sensitive to Sweets
☐My teeth are sensitive to Biting/Chewing
☐My teeth are sensitive to Cold
☐My teeth are sensitive to Hot
☐I am aware of cavities
☐I wear dentures or partials
☐I am aware of odors or bad tastes in my mouth
☐My gums bleed when I brush my teeth
☐My gums feel swollen and/o tender
☐Food catches between my teeth when I eat
☐I have difficulty chewing
☐I can only chew on one side of my mouth
☐I have been treated for periodontal disease
☐I have worn braces in the past
☐I am not satisfied with the appearance of my smile

How often do you brush your teeth? _____ Floss? _____
Date of last dental visit:_____ Date of last x-rays _____

Authorization

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I consent to the examination and any diagnostic and therapeutic procedures that may be necessary for proper care by the doctor.
I hereby authorize the release of any information related to insurance claims and authorize payment of any insurance benefits to the office.
I acknowledge that I am financially responsible for any balance due as result of treatment received.

Signature_____ Date_____