Patient's Name_____Date of Birth_____Sex M F

Street Address_____City_____State_____Zip_____

Employment_____Occupation_____

Patient's Social Security Number:_____ E-Mail:_____

Home Phone #_____Work Phone #_____ext_____Cell Phone #_____

Spouse's name_____Contact#_____Emergency Contact/#_____

Other family members who are also patients_____

Who recommended us to you?_____

CIRCLE ANY OF THE FOLLOWING YOU HAVE EVER HAD:

Artificial Heart Valve	Diabetes	Tuberculosis	Osteoporosis
Mitral Valve Prolapse	Epilepsy	High Blood Pressure	HIV
Heart Murmur	Hepatitis A or B	Asthma	Heart Trouble
Artificial Joint Replacement	Hepatitis C	Chemotherapy	Rheumatic Fever
Bleeding Disorder	Glaucoma	Pacemaker	
Congenital Heart Defect			

MEDICAL HISTORY

YES NO

___ ___Have you ever had an unusual reaction or allergy to any drug, anesthetic, or latex?
If so, what?_____

___ ___Are you currently taking any drugs or medications? what?_____

___ ___Are you currently under the care of a physician? why?_____

___ ___Have you ever had serious trouble with prolonged bleeding after a cut or injury?

___ ___Women: Are you pregnant? Expected delivery date:_____

___ ___Have you ever had serious trouble associated with any previous dental treatment?
If so, please explain_____

90% of oral cancer occurs in people who use tobacco and consume alcohol

___ ___Do you smoke? Packs per day:_____

___ ___Do you use smokeless tobacco? How often?_____

___ ___Do you consume more than seven drinks of alcohol per week?

___ ___Have you ever been diagnosed with periodontal disease or referred to a periodontist?

___ ___Would you like to be given a prescription for a sedative to take prior to your dental appointments? Someone will need to drive you to and from your appointment.

___ ___Is there anything about your teeth you would like to change? _____

Child's Parent or Guardian_____

Work Phone_____Cell Phone_____

Name of Dental Insurance Plan_____Group#_____

Name of person who holds insurance(the cardholder)_____

If the patient is not the cardholder, please provide the following information we must have to file your insurance:

Where does the cardholder work?_____

What is the cardholder's Social Security number?_____

What is the contract number?_____

What is the group number?_____

What is the cardholder's date of birth?_____

What is the cardholder's relationship to the patient?_____

As with any medical procedure, dental treatment involves some risk of complications.
The most common are:
(1) adverse reactions to drugs or anesthetics
(2) post operative pain, bleeding, or infection
(3) treatment failure requiring tooth extraction
(4) nerve damage causing prolonged or permanent lip, tongue, or gum tingling or numbness
(5) jaw or joint pain
(6) broken instruments
(7) sinus perforations

If a problem occurs after treatment, please call our office for any necessary follow up care.

There are often alternative procedures available for dental problems, one of which is no treatment at all. Please feel free to question Dr. Grantham or any staff member at any time about alternative treatments.

If I ever have any changes in my health, I will inform the office staff or change my medical history.

I have read and understand the preceding risks.

Signature:_____Date:_____

Please initial:

_____Insurance coverage is **estimated** based on information available at the time of service. Estimated patient co-pays and deductibles are due at the completion of each appointment.

_____Any portion remaining after insurance pays is due directly by patient.