John S Grisham DDS PC - 6/26/2020

About You

About You

Today's Date	What You Prefer To Be Called	Gender	Birthdate
Age	SS #	Mailing Address	City
State	Zip	Home Phone #	Work Phone #
Cell Phone #	Email Address	Referred By	

Employer

Are you employed?

Employer Name	How Long?	Employer's Address	City
State	Zip	Occupation	

More About You

Status	Spouse's Name (if applicable)	Do you have children?

Insurance Information

Primary Insurance

Insurance Company Name	Insurance Company's Address	City	State
Zip	Insurance Company Phone #	Insured's ID #	Group # (Plan, Local, or Policy #)
Insured's Name	Relation	Date of Birth	Insured's Employer

Secondary Insurance

Does the patient have secondary insurance?

Insurance Company Name	Insurance Company's Address	City	State
Zip	Insurance Company Phone #	Insured's ID #	Group # (Plan, Local, or Policy #)
Insured's Name	Relation	Date of Birth	Insured's Employer

Account Information

Account Information

Person ultimately responsible for account

Name	Relation	Billing Address	City
State	Zip	SS #	Drivers License #
Work Phone #	Payment method	Credit Card #	Expiration Date

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office.)

Initials

Emergency Contact

Emergency Contact

Whom should we contact?	Relation	Home Phone #	Work Phone #
Cell Phone #			
Who is your Medical Doctor?		Medical Doctor's Phone #	

Dental Information

Dental Information

Reason for today's visit			Are you in pain?

Please indicate "Yes" if you have any of the following problems:

Discomfort, clicking or popping in jaw	Blisters/Sores in or around the mouth	Red, swollen or bleeding gums	Lost/Broken Filling(s)
Teeth grinding	Ringing in Ears	Stained teeth	Locking Jaw
Bad breath	Broken/Chipped tooth	Sensitive tooth, teeth or gums	Active Decay/Cavity(ies)
Other			

Additional Dental Information

Do you require pre-medication?	Have you ever been treated for Gum Disease?

Dental History

Previous Dentist			
Name / Practice Name	Address	Phone #	Last Dental Exam
Last Dental X-rays	Last Dental Cleaning		Have you had problems with previous dental treatment?

Dental Habits

Times a day you brush?	Times a week you floss?	Type of tooth brush bristles?	Times a day you brush?
Rate your Smile from 1-10		Would you like whiter teeth?	Have you had orthodontic treatment?
Things you would change about your smile?			

Medical History & Information

Medical History

What medications are you taking?			
Nerve pills	Pain killers (including aspirin)	Muscle relaxers	Stimulants
Blood Thinners	Tranquilizers	Insulin	Meds for Osteoporosis
Vitamins/Supplements	If yes, please list:	Other(s)	If yes, please list:

Have you ever taken Bisphosphonates (ex. Aredia/Fosamax)	Have you ever taken Phen-fen/Redux

Medical Conditions

Do you have or have you had any of the following diseases, medical conditions or procedures?

Heart Murmur	Lung Disease	Liver Problems	Blood Disease
Kidney Problems	Scarlet Fever	Tuberculosis TB	HIV+ /AIDS/ARC
Rheumatic Fever	Sinus Problems	Heart Attack/Stroke	Thyroid Problems
Seizures/Epilepsy	Venereal Disease	Cosmetic Surgery	Dizziness/Fainting
Cold/Fever Blisters	Blood Transfusion	Alcohol/Drug Abuse	Eating Disorder
Heart Surgery/Pacemaker	Congenital Heart Defect	Artificial Heart Valves	Mitral Valve Prolapse
G.I. Problems/Ulcers	Emphysema/Asthma	Diabetes/Hypoglycemia	Psychiatric Problems
Back/Neck Problems	Respiratory Problems	Heart Disease/Angina	Cancer/Tumor(s)/Growth(s)
Chemotherapy/Radiation	X-ray or Cobalt Treatment	Frequent Thirst/Urination	Bleeding Problems/Anemia
High/Low Blood Pressure	Artificial Bones/Joints/Implants	Severe/Frequent Headaches	Jaw Problems TMJ/TMD
Shingles	Hepatitis	Glaucoma	Arthritis/Gout

Leukemia	Chest Pains	Bruise Easily	Allergies
Nervousness	Sleep Apnea		
Please list any other surgeries or medical conditions you have or ever had			

Medical Information

Are you allergic to any of the following?			
Latex	Penicillin / Amoxicillin	Tetracycline	Aspirin
Codeine	Dental Anesthetics	Foods	If yes, please list:
Other	If yes, please list:	Do you use tobacco?	Please rate your general health from 1-10
Do you wear contact lenses?			

Female Patients

Are you a female patient?			
Are you taking Birth Control pills?	Are you taking hormonal replacement?	Are you Pregnant?	Are you nursing?
How many children have you had?			

Acknowledgement

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We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
I acknowledge that I have received a copy of the Summary of Privacy Notice.
Signature of Patient/Parent or Guardian/Spouse
Date