Welcome

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

The Staff at Griswold Dental Associates

Patient Information (Confidential)

Today's Date _____

Name _____ Birth Date _____

Nickname/Preferred Name _____ Social Sec. # _____

Address _____ Home Phone #_____

City _____ Work Phone #_____

State _____ Zip _____ Cell Phone # _____

Email Address_____ Please circle preferred phone # to contact you

Patient's or Parent's Employer _____

Business Address _____

Whom May We Thank for Referring You _____

Emergency Contact _____ Phone # _____

Responsible Party

Name of Person Responsible for this Account _____

Address _____ Phone # _____

City _____State _____Zip _____ Relationship _____

Full payment is due when services are rendered. For this, you receive a 5% courtesy reduction of the charge (10% if you are over 60). For your convenience, we offer the following methods of payment: Cash, Personal Check, VISA and MasterCard

Financial Agreement

By signing below, I acknowledge that I understand my financial responsibilities. Regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. Should my account become delinquent, I agree to pay a collection fee of 25% of my unpaid balance.

Signature of Responsible Party _____ Date _____

HIPAA Consent

I have been shown a copy of Griswold Dental Associates Notice of Privacy Practices.

Signature of Responsible Party _____ Date _____

Name:_____ Date:_____

Patient Medical History (Please Mark Any Yes Answers)

- ☐ Are you in good health?
- ☐ Have there been any changes in your general health in the past year?
- ☐ Are you under the care of a physician?
- ☐ Have you ever been hospitalized for any surgical operation or serious illness?
- ☐ Are you taking any medicine including non-prescription medicine or herbal supplements? If yes, please list medications:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Have you had any abnormal bleeding?
- ☐ Do you bruise easily?
- ☐ Have you ever required a blood transfusion?
- ☐ Have you had a recent unexplained weight loss?
- ☐ Do you use tobacco?
- ☐ Do you or have you used controlled substances? (There is a potential for severe interaction with meds we use in the office.)

Women Only:

- ☐ Are you pregnant or think you may be pregnant?
- ☐ Are you nursing?
- ☐ Are you taking birth control pills?

Are You Allergic To or Have You Had Reactions To:

- ☐ Local Anesthetics like Novocaine
- ☐ Penicillin or other antibiotics
- ☐ Aspirin
- ☐ Other (including environmental)_____
- ☐ Iodine
- ☐ Any metals (e.g. nickel, mercury, etc.)
- ☐ Latex/rubber

Do You Have or Have You Ever Had the Following:

- ☐ Heart Surgery
- ☐ High/low blood pressure
- ☐ Congenital heart problems
- ☐ Heart defect or heart murmur
- ☐ Heart trouble, heart attack or angina
- ☐ Swelling of feet, ankles, hands
- ☐ Stroke
- ☐ Mitral valve prolapse
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pacemaker
- ☐ Stomach ulcer
- ☐ Kidney trouble (including dialysis)
- ☐ Tuberculosis
- ☐ Persistent cough
- ☐ Cough that produces blood
- ☐ Chemotherapy (cancer, leukemia)
- ☐ Sexually transmitted disease
- ☐ Epilepsy or seizures
- ☐ Anemia
- ☐ Glaucoma
- ☐ Tumors
- ☐ Nervousness
- ☐ Mental health care
- ☐ Chemical dependency
- ☐ Steroid treatment (e.g. Prednisone, Cortisone)
- ☐ Hypoglycemia
- ☐ Eating disorders
- ☐ Sinus trouble
- ☐ Asthma or hay fever
- ☐ Diabetes
- ☐ AIDS or HIV
- ☐ Thyroid problems
- ☐ Arthritis or rheumatism
- ☐ Joint replacement or implant

- ☐ Do you have any disease, condition or problem not listed above that you think I should know about?_____

My last dental visit was _____

Please list any dental concerns that you would like to discuss with us (sensitivity, esthetics, etc.)

_____

_____