PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Birthdate:_____ Soc. Sec.: _____ Gender: OMale OFemale

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: _____ Fax: _____ Email: _____

Employer: _____Phone: _____ Occupation: _____

Referred By: _____ General Dentist: _____

Have you been seen in this practice before today? OYes ONo

PERSON RESPONSIBLE FOR ACCOUNT (If other than patient)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: Patient Spouse Child Other-please specify_____

Address: _____ Apt./Suite: _____ Soc. Sec.: _____DOB: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: _____ Fax: _____ Email: _____

Employer: _____Phone: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance:

Ins. Co. _____

Group # _____

Employer: _____

EMPLOYEE (If other than Patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.:_____

Subscriber #: _____ OMale OFemale

Secondary Insurance:

Ins. Co. _____

Group #_____

Employer: _____

EMPLOYEE (If other than Patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.:_____

Subscriber #: _____ OMale OFemale

_____ _____

Signature (Parent or guardian if patient is a minor) Date

Patient's Name _____ **Date** _____

Date of last health care examination_____Current Age _____

Have you been hospitalized the last 5 years? _____If so, for what?_____

Do you have, or have you ever had:

	Yes	No		Yes	No
Anemia	___	___	Any type of Implants?		
Epilepsy	___	___	(Heart Valve, Pacemaker, Hip Knee,	___	___
Diabetes	___	___	Implant or Augmentation)		
Tuberculosis	___	___	Location in bodyé é é é .. _____		
			Are you being treated for		
			Abnormal Blood Pressure?	___	___
Rheumatic Fever	___	___	Do you take steroids or cortisone		
Heart Murmur	___	___	on a daily basis?	___	___
Mitro Valve Prolapse	___	___	Are you taking any blood thinners?	___	___
Hepatitus	___	___	Are you **allergic** to:		
Abnormal Heart			Penicillin	___	___
Condition	___	___	Local Anesthetic	___	___
Abnormal bleeding			Other Medication or drugs	___	___
from a cut?	___	___			
TMJ ?	___	___	Asthma?	___	___
HIV/AIDS	___	___	Radiation (X-ray) treatment for cancer	___	___
Do you smoke?	___	___	Do you use chew tobacco?	___	___

How much per day? _____For how long? _____ For how long? _____

Are you ***taking*** or ***have you ever taken*** Bisphosphonates (Fosamax or Actonel for osteoporosis), or Zometa or Aredia (Chemotherapy) for breast cancer, multiple myeloma, etc?. . . . . ___ ___

Women Only:

Are you pregnant or is there any chance you might be pregnant?. . . . . ___ ___

Are you nursing?. . . . . ___ ___

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

If allergic to medications or drugs, indicate which ones_____

_____

Please list any medications and/or vitamins or herbal supplements you are taking now_____

_____

_____

Other physical conditions we should be aware of _____

Name of physician _____Phone_____

Are you receiving care now? _____ If so, nature of care _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Date _____

Signature of patient or person completing health history form *(and relationship if other than patient)*

Dental / Medical Insurance Information:

For multiple extractions and surgeries, please fill out an insurance information sheet and give your ID cards to receptionist so we can make a copy. The insurance coordinator will consult with you.
For single tooth extractions, we do not file insurance unless we are a provider on your insurance plan. If we are a provider for your insurance company, please fill out an insurance information sheet and give your ID cards to the receptionist so we can make a copy.

RELEASE

I authorize release of any information concerning my (or my childôs) health care, advice and treatment to another healthcare provider.

NO cell phone use allowed in surgical suitesô and recovery areas. NO cell phone calls, photos and/or videotaping/recording. This is due to the HIPAA confidentiality regulations.
Thank you for your cooperation and respect for our patientsô and employeesô privacy.

I agree to pay the amount owed for this visit. If my insurance is filed, I understand Dr. Granthamôs office accepts no responsibility regarding what my insurance company will or will not pay. I authorize the release of any information concerning my condition necessary to process any claim regarding my account. I authorize assignment of all benefits directly to Dr. Grantham. I fully understand that if I discontinue care prior to being discharged, my account is payable in full upon demand. I certify that I agree to the above and have had it explained to me so that I fully understand it.

_____ _____
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have been advised that a copy of this officeôs Notice of Privacy Practices is available to me upon request.

_____ _____
{Print Name of Patient} **{Patient Date of Birth}**

_____ _____
{Signature of Patient or Parent/Guardian if a minor} **{Date}**

I allow you to give my clinical information to or answer questions from (*check all that apply*):

☐ Spouse ☐ Parent ☐ Child Name: _____
☐ Name:_____ _____
☐ Name:_____ _____
☐ None

May we leave a detailed message on your **home** / **cell** phone? Yes / No
(If YES, circle one or both)