HEALTHY TEETH • BEAUTIFUL SMILES

RANDOLPH GRYEBET D.D.S.
ROBERT GRYEBET D.D.S.

PATIENT INFORMATION

Date: _____ Home Phone:_____ Cell Phone:_____

Name:_____ SS/HIC/Patient ID#: _____

Address:_____ Email:_____

City:_____ State:_____ Zip:_____

Sex: M / F Age:_____ Birthday:_____ Marital Status: Married / Single / Other

Patients Employer/School:_____ Occupation:_____

Employer/School Address:_____ Phone:_____

Whom may we thank for referring you?:_____ Phone:_____

In case of emergency, who may we contact?: _____

INSURANCE INFORMATION

Primary Insurance:_____ Person Responsible for Account: _____

Relation to Patient:_____ Birthdate:_____ Soc. Sec.#:_____

Person Responsible Employed By:_____

ID/Contract#:_____ Group#:_____

Additional Insurance:_____ Person Responsible for Account: _____

Relation to Patient:_____ Birthdate:_____ Soc. Sec.#:_____

Person Responsible Employed By:_____

ID/Contract#:_____ Group#:_____

INFORMED CONSENT

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges wether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determing insurance benefits of the benefits payable for related services.

Signature:_____ Date:_____
(Signature of patient, parent, guardian, or personal representative)

Print:_____
(Please print name of patient, parent, guardian, or personal representative)

DENTAL HISTORY

Reason for todays visit:_____ Date of last dental care:_____

Check if you have any problems with the following:

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Sensitivity to Hot
- ☐ Bleeding Gums
- ☐ Loose/Broken teeth
- ☐ Sensitivity to sweets
- ☐ Sensitivity to cold
- ☐ Periodontal treatment
- ☐ Sensitivity when biting
- ☐ Food collection between teeth
- ☐ Clicking and popping jaw
- ☐ Sores or growths in your mouth
- ☐ Persistent cough unrelated to illness
- ☐ Numbness in and around mouth
- ☐ Trouble speaking
- ☐ One sided muscle weakness
- ☐ Hard lumps on your neck or mouth
- ☐ Constant need to clear throat
- ☐ Extremely dry mouth
- ☐ Diagnosed with HPV
- ☐ Previous Gum Treatments/ Deep cleanings
- ☐ Taking Blood Thinner
- ☐ High sugar intake (soda/candy)
- ☐ Sensitive gag reflex

MEDICAL HISTORY

Are you currently taking medications considered blood thinners? Y / N

Have you ever used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Boniva) Y / N

Have you ever taken “fen-phen” or other drugs in this group? Y / N

Have you ever had any serious illness or operations? Y / N If yes, describe_____

Have you ever had a blood transfusion? Y / N if yes please give date

(Women) Are you pregnant? Y / N Nursing? Y / N Taking birth control? Y / N

Are you taking any prescription/over-the-counter drugs? Y / N

Please list each one: _____

_____

_____

Check if you have any of the following:

- ☐ Anemia
- ☐ Cortisone treatments
- ☐ Hepatitis
- ☐ Scarlet fever
- ☐ Arthritis
- ☐ Cough, Persistent
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Heart murmur
- ☐ Abnormal bleeding
- ☐ Artificial heart valve
- ☐ Cough up blood
- ☐ HIV/ AIDS
- ☐ Skin rash
- ☐ Artificial joints
- ☐ Diabetes
- ☐ Jaw pain
- ☐ Stroke
- ☐ Drug/Alcohol abuse
- ☐ Fever blisters/Herpes
- ☐ Asthma
- ☐ Epilepsy/ Seizures
- ☐ Kidney disease
- ☐ Swelling of feet or ankles
- ☐ Back problems
- ☐ Fainting
- ☐ Liver disease
- ☐ Thyroid problems
- ☐ Congenital heart defect
- ☐ Blood disease
- ☐ Glaucoma
- ☐ Psychological disorders
- ☐ Tobacco habit
- ☐ Cancer
- ☐ Headaches
- ☐ Pacemaker
- ☐ Tonsillitis
- ☐ History of heart attack
- ☐ Mitral valve prolapse

ALLERGIES

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Dental Anesthetics ☐ Latex ☐ Penicillin ☐ Tetracycline ☐ Jewelry/Metals

Please list any other drugs/materials that you are allergic to:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to preform any necessary dental service that I may need during diagnosis and treatment with my informed consent.

Signature:_____ Date:_____

MEDICAL HISTORY UPDATE (OFFICE USE ONLY)

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____