CONFIDENTIAL MEDICAL DENTAL HISTORY

Dr. Lisa Grant D.D.S. M.S.

Patient

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date: _____

Social Security # _____ Birth Date: _____

Phone: _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address: _____ (Street) _____ (Apartment #)

_____ (City) _____ (State) _____ (Zip Code)

Medical Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Current Medications:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # Birth Date:

Phone: (Work): Ext: Best time to call:

Address:
Street Apartment #

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer name: Group Number: Group ID:

Dental Insurance Company:
Phone

Dental History

Current Dentist:

Do you have any current dental problems?

1) Date of last complete dental examination
2) Are your teeth sensitive?
3) Do your gums bleed or hurt?
4) Have you noticed any loose teeth or change in your bite?
5) Have you noticed any mouth odors or bad tastes?
6) Does food tend to become caught between your teeth?
7) Do you clench or grind your teeth?
8) Have you ever had orthodontic treatment?
9) Have you ever seen a periodontist?
10) Has your bite ever been adjusted?
11) Do you have clicking or popping in your jaw?
12) Do you have difficulty opening or closing your mouth?
13) Have you been told you have a TMJ problem?
14) Do you get frequent headaches?
15) Would you like to keep your teeth all your life?
16) Do you feel nervous about having dental treatment?
    If yes, what is your biggest concern?
17) Have you ever had an upsetting dental experience
    If yes, what is your biggest concern?
18) Are you happy with the appearance of your teeth?
    If no, what would you like to change?

Consent for Services

1) I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3) I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I can ask for a complete recital on any possible complication.
4) I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.
5) I hereby give Lisa Grant Orthodontics the absolute right and permission to use my photographs / slides for educational or promotional purposes via print or social media. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Signature of patient, parent or guardian Date Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ have received / read a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknow ledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
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