Grove City family dentistry

The quality & care you need. **Guaranteed.**

ID: _____ Chart ID _____

First name _____ Last name _____ Middle initial ____ Preferred name _____

Patient is : Policy holder Responsible party

Responsible Party (if someone other than patient)

First name _____ Last name _____ Middle Initial ____

Address _____ Address 2 _____

City, State, Zip _____ Pager _____

Home phone _____ Work phone _____ Ext _____ Cell phone _____

Birth date _____ Social security # _____ Drivers license # _____

◯ Responsible Party is also a Policy holder for patient ◯ Primary insurance policy holder ◯ Secondary insurance policy holder

Patient Information

First name _____ Last name _____ Middle initial ____

Address _____ Address 2 _____

City, State, Zip _____ Pager _____

Home phone _____ Work phone _____ Ext _____ Cell phone _____

Sex: ◯ Male ◯ Female Marital status ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth date _____ Age ____ Social security # _____ Drivers license # _____

Email _____ ◯ I would like to receive correspondences via email

Section 2

Employment Status ◯ Full time ◯ Part time ◯ Retired

Student Status ◯ Full time ◯ Part time

Medicaid ID _____ Preferred Dentist _____

Employer ID _____ Preferred Pharmacy _____

Carrier ID _____ Preferred Hygienist _____

Section 3

Preferred apointment time _____

Who referred you _____

Best number to call _____

Time to call you _____

Emergency name _____

Emergency number _____

Primary Insurance Information

Name of insured _____ Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured social security # _____ Insured birth date _____

Employer _____ Insurance company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Rem. Benefits ____ .00 Rem. Deductible ____ .00

Secondary Insurance Information

Name of insured _____ Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured social security # _____ Insured birth date _____

Employer _____ Insurance company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Rem. Benefits ____ .00 Rem. Deductible ____ .00

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Patient Name _____ Birth Date _____ Date Created _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

◯Y ◯N Are you under a physician's care now? If yes, please explain _____

◯Y ◯N Have you ever been hospitalized or had a major operation? If yes, please explain _____

◯Y ◯N Have you ever had a serious head or neck injury? If yes, please explain _____

◯Y ◯N Are you taking any medication, pills, or drugs? If yes, please explain _____

◯Y ◯N Have you ever taken any meds containing bisphosphonates or IV bisphosphonates ie: Fosamax, Boniva, Actonel? If yes, please explain _____

◯Y ◯N Do you use tobacco/nicotine products ie: cigarettes, smokeless tobacco, e-cigs? If yes, please explain _____

Women are you:

◯Y ◯N pregnant or trying to get pregnant? ◯Y ◯N Nursing? ◯Y ◯N Taking oral contraceptives?

Are you allergic to the following:

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local anesthetics

◯ Other, if yes please explain _____

Do you have, or have you had, any of the following?

◯Y ◯N Snoring ◯Y ◯N Restless Sleep ◯Y ◯N Jaw Pain ◯Y ◯N Teeth Clenching ◯Y ◯N Teeth Grinding

Do you have, or have you had, any of the following?

◯Y ◯N ADHD
◯Y ◯N AIDS/HIV Positive
◯Y ◯N Alzheimer's Disease
◯Y ◯N Anaphylaxis
◯Y ◯N Anemia
◯Y ◯N Angina
◯Y ◯N Arthritis/Gout
◯Y ◯N Artificial Heart Valve
◯Y ◯N Artificial Joint
◯Y ◯N Asthma
◯Y ◯N Autism/Autism Spectrum Disorder
◯Y ◯N Blood Disease
◯Y ◯N Breathing Problem
◯Y ◯N Bruise Easily
◯Y ◯N Cancer
◯Y ◯N Chemotherapy
◯Y ◯N Chest Pains
◯Y ◯N Cold Sores/Fever Blisters
◯Y ◯N Congenital Heart Disorder
◯Y ◯N Cortisone Medication
◯Y ◯N Developmental Disorder
◯Y ◯N Diabetes
◯Y ◯N Drug Addiction
◯Y ◯N Easily Winded
◯Y ◯N Emphysema
◯Y ◯N Epilepsy or Seizures
◯Y ◯N Excessive Bleeding
◯Y ◯N Excessive Thirst
◯Y ◯N Fainting Spells/Dizziness
◯Y ◯N Frequent Cough
◯Y ◯N Frequent Headaches
◯Y ◯N GERD/Chronic Heartburn
◯Y ◯N Glaucoma
◯Y ◯N Hay Fever
◯Y ◯N Heart Attack/Failure
◯Y ◯N Heart Murmur
◯Y ◯N Heart Pace Maker
◯Y ◯N Heart Trouble/Disease
◯Y ◯N Hemophilia
◯Y ◯N Hepatitis A
◯Y ◯N Hepatitis B or C
◯Y ◯N Herpes
◯Y ◯N High Blood Pressure
◯Y ◯N High Cholesterol
◯Y ◯N Hives or Rash
◯Y ◯N Hypoglycemia
◯Y ◯N Irregular Heartbeat
◯Y ◯N Kidney Problems
◯Y ◯N Leukemia
◯Y ◯N Liver Disease
◯Y ◯N Low blood Pressure
◯Y ◯N Lung Disease
◯Y ◯N Mitral Valve Prolapse
◯Y ◯N Obstructive Sleep Apnea
◯Y ◯N Osteoporosis
◯Y ◯N Pain in Jaw Joints
◯Y ◯N Parathyroid Disease
◯Y ◯N Psychiatric Care
◯Y ◯N Radiation Treatment
◯Y ◯N Renal Dialysis
◯Y ◯N Rheumatic Fever
◯Y ◯N Rheumatoid Arthritis
◯Y ◯N Shingles
◯Y ◯N Sickle Cell Disease
◯Y ◯N Sinus Trouble
◯Y ◯N Spina Bifida
◯Y ◯N Stomach/Intestinal Disease
◯Y ◯N Stroke
◯Y ◯N Thyroid Disease
◯Y ◯N Tonsilitis
◯Y ◯N Tuberculosis
◯Y ◯N Tumors or Growths
◯Y ◯N Ulcers

Have you ever had any serious illness not listed above? If yes, please explain. ◯Y ◯N _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian _____ Date _____