# Welcome!

## GRUNWALD FAMILY DENTISTRY

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## Patient Information

Date ______ Soc. Sec. # ______ Birthdate ______

Name ______ (Last Name / First Name / Initial) Home Phone ______

Address ______ Cell Phone ______

City ______ State ______ Zip ______ E-mail ______

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ______ Business Phone ______

Business Address ______ Occupation ______

Who should we thank for referring you? ______

In case of emergency, who should we contact? ______ Phone ______

## Primary Insurance

Person Responsible for Account ______ (Last Name / First Name / Initial)

Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______

Address ______ Home Phone ______

City ______ State ______ Zip ______

Responsible Party Employed By ______ Business Phone ______

Business Address ______ Occupation ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

## Additional Insurance

Insured Name ______ (Last Name / First Name / Initial)

Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______

Address ______ Home Phone ______

City ______ State ______ Zip ______

Insured Employed By ______ Business Phone ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

PLEASE COMPLETE REVERSE SIDE

# Dental History

Former Dentist ______________________

City, State ______________________

Date of Last Dental Visit ______________________

Date of Last X-Rays ______________________

How Often Do You Floss? ______________________

How Often Do You Brush? ______________________

| | Yes | No |
|---|---|---|
| Bad Breath | ☐ | ☐ |
| Bleeding Gums | ☐ | ☐ |
| Blisters on Lips or Mouth | ☐ | ☐ |
| Grinding Teeth | ☐ | ☐ |
| Loose Teeth or Broken Fillings | ☐ | ☐ |
| Orthodontic Treatment | ☐ | ☐ |
| Pain Around Ear | ☐ | ☐ |
| Periodontal Treatment | ☐ | ☐ |
| Sensitivity to Cold / Hot | ☐ | ☐ |
| Sensitivity When Biting | ☐ | ☐ |
| Frequent Headaches | ☐ | ☐ |
| Jaw, Head or Neck Injuries | ☐ | ☐ |
| Jaw Difficulty: Clicking and/or Pain | ☐ | ☐ |
| Tooth Pain | ☐ | ☐ |

# Medical History

Physician's Name ______________________ Date of Last Visit ______________________

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations? | ☐ | ☐ |

Please list ______________________

| | Yes | No |
|---|---|---|
| 3. Are you currently taking any medication? | ☐ | ☐ |

Please list medications ______________________

______________________

| | Yes | No |
|---|---|---|
| 4. Do you use tobacco? | ☐ | ☐ |
| 5. Do you use alcohol? | ☐ | ☐ |
| 6. Do you use drugs? | ☐ | ☐ |
| 7. Have you ever been premedicated for dental procedures? | ☐ | ☐ |

8. Have you had any allergic reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates (sleeping pills) | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Other | ☐ | ☐ |

9. (Women Only) Are You:

| | Yes | No |
|---|---|---|
| Pregnant? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Acid Reflux | ☐ | ☐ |
| AIDS/HIV | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Arthritis, Rheumatism | ☐ | ☐ |
| Artificial Heart Valves | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Bleeding abnormally, with extractions or surgery | ☐ | ☐ |
| Blood Disease | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ |
| Cholesterol | ☐ | ☐ |
| Chronic Fatigue Syndrome | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ |
| Cortisone Treatments | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Fainting or Dizziness | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Hepatitis-Type ______ | ☐ | ☐ |
| Herpes | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |
| Latex Sensitivity | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Psychiatric Care | ☐ | ☐ |
| Radiation Treatment | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ |
| Sleep Apnea | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Swelling of Feet/Ankles | ☐ | ☐ |
| Swollen Neck Glands | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |
| Tonsillitis | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Tumor or growth on head/neck | ☐ | ☐ |
| Ulcer | ☐ | ☐ |
| Venereal Disease | ☐ | ☐ |
| Other | ☐ | ☐ |

# Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize Dr. Grunwald and her staff to provide dental care to myself and/or my minor child.

Signature of Responsible Party ______________________ Date ______________________