

Richard D. Gruntz, DDS PC
1600-L Crystal Square Arcade
Arlington, VA 22202

(703) 412-1122

Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex M F Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Home Phone () _____ Cell Phone () _____ Email Address _____

Employer _____ Employer Phone () _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone () _____

Whom may we thank for referring you _____

Person to contact in case of emergency _____ Phone () _____

RESPONSIBLE PARTY

Name of Person _____ Relation to Patient _____
Responsible for this Account _____

Address _____ Home Phone () _____

Birthdate _____ Currently a patient in our office Yes No

Employer _____ Work Phone () _____

E-Mail _____ Cell Phone () _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-ray _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken filling | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date _____

(Women) Do you suspect you are pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had problems with any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortison Treatments | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bisphosphonates
Oral or IV |

List medications you are currently taking:

Allergies:

- | | | | |
|--|---|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> None | |

Is there anything else that we should know about your medical history? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever had a change in health.
I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient