gratitude dental

Patient Registration

Patient Information

First Name______________________ Last Name_____________________ Sex Assiged at Birth M F Birthdate ____________________

Street Address ____ City ______________________ State ___________ Zip __________

Single Married Widowed Separated Divorced Social Security # __________ - _______ - __________ Cell Phone _____________________

Email ____ Work Phone ____________________

Work Address ____ City ______________________ State ___________ Zip __________

If Student: Name and City/State of School ____ Grade _________

Person to contact for emergency __________________________________ Relationship _______________ Phone ________________________

Whom may we thank for referring you? ____

Account and Insurance Information

Person Responsible for Account ____ Relationship to Patient ___________________

Birthdate ____________________ Driver's License # ______________________________ Social Security # __________ - _______ - __________

Street Address ____ City ______________________ State ___________ Zip __________

Responsible Party's Employer ____ Work Phone __________________

Work Address ____ City ______________________ State ___________ Zip __________

Insurance Company ____

Contract # _____________________________Group # ___________________________________ Subscriber # __________________________

Secondary Insurance Information

Subscriber Name ____ Relationship to Patient __________________

Birthdate ____________________ Driver's License # ______________________________ Social Security # __________ - _______ - __________

Street Address (if different) _______________________________________ City ______________________ State ___________ Zip __________

Subscriber's Employer ____ Work Phone __________________

Work Address ____ City ______________________ State ___________ Zip __________

Insurance Company ____

Contract # _____________________________Group # ___________________________________ Subscriber # __________________________

Policy of the Office and Consent for Treatment

I certify that the above information is correct and hereby assign directly to Dr. Chris French all insurance benefits, in any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not insured, and that any co-payments and non-insured services are due at the time of service. I hereby authorize Dr. French to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions placed on my behalf. I also understand that I may be subject to a $50 fee for canceling an appointment without at least 24 hours notice. I hereby authorize Dr. French or designated staff to administer any treatment and to administer such ×-rays, anesthetic, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

Patient/Guardian Signature: ____ Date: ____________________

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Patient Name: ______________________________

Health History Form

Name and phone number of your primary care physician:____

Please indicate "Yes" or "No".

If you answered "Yes" to any questions, please elaborate in the space below.

- ▢ Yes ▢ No 1. Are you having pain or discomfort at this time?
- ▢ Yes ▢ No 2. Any major changes to your health in the past year?
- ▢ Yes ▢ No 3. Any previous hospitalization?
- ▢ Yes ▢ No 4. Any previous surgeries?
- ▢ Yes ▢ No 5. Any serious trouble associated with previous dental treatment?
- ▢ Yes ▢ No 6. Any excessive bleeding requiring treatment?
- ▢ Yes ▢ No 7. Any trouble with anesthetic?
- ▢ Yes ▢ No 8. Were you advised by your doctor to take antibiotic pre-medication before dental appointments?
- ▢ Yes ▢ No 9. (Women) Are you pregnant or planning to become pregnant?

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10. Please indicate if you have ever had the following medical conditions:

- ▢ Yes ▢ No Rheumatic fever or rheumatic heart disease
- ▢ Yes ▢ No Heart defect or heart disease from birth
- ▢ Yes ▢ No Heart murmur
- ▢ Yes ▢ No Cardiovascular disease, including
  - Heart attack
  - Coronary artery disease
  - Angina
  - Stroke
  - Palpitations
  - Heart surgery
  - Pacemaker
- ▢ Yes ▢ No High blood pressure
- ▢ Yes ▢ No Lung disease, Asthma, Emphysema, Bronchitis Pneumonia, or Tuberculosis
- ▢ Yes ▢ No Seizures, convulsions, epilepsy or fainting
- ▢ Yes ▢ No Psychiatric treatment
- ▢ Yes ▢ No Bleeding disorder, anemia, or blood transfusion
- ▢ Yes ▢ No Diabetes Type I or II
- ▢ Yes ▢ No Kidney disease
- ▢ Yes ▢ No Liver disease (i.e. Jaundice, Hepatitis)
- ▢ Yes ▢ No Thyroid disease
- ▢ Yes ▢ No Bone disease (i.e. Osteoporosis)
- ▢ Yes ▢ No Arthritis
- ▢ Yes ▢ No Stomach ulcers or colitis
- ▢ Yes ▢ No Glaucoma
- ▢ Yes ▢ No Implants placed in the body (i.e. heart valve, hip, knee)
- ▢ Yes ▢ No Cancer
- ▢ Yes ▢ No Radiation treatment for cancer
- ▢ Yes ▢ No Clicking or popping of jaw joint causing pain
- ▢ Yes ▢ No Sinus or nasal problems
- ▢ Yes ▢ No Immunocompromised due to transplant or drugs
- ▢ Yes ▢ No Recurring infections of any kind
- ▢ Yes ▢ No HIV/AIDS
- ▢ Yes ▢ No Other (please describe):

11. Are you **currently** taking any of the following medications?

- ▢ Yes ▢ No Anticoagulants (i.e. Eliquis) or blood thinners
- ▢ Yes ▢ No Aspirin
- ▢ Yes ▢ No Ibuprofen (i.e. Motrin, Advil)
- ▢ Yes ▢ No Antibiotics or sulfa drugs
- ▢ Yes ▢ No Tranquilizers (i.e. Valium, Xanax)
- ▢ Yes ▢ No Thyroid medications
- ▢ Yes ▢ No Blood pressure medication
- ▢ Yes ▢ No Steroids, cortisone, etc.
- ▢ Yes ▢ No Osteoporosis drugs (i.e. Fosamax, Actonel)
- ▢ Yes ▢ No Insulin or other medications for diabetes
- ▢ Yes ▢ No Heart medications (i.e. Digitalis, Nitroglvcerin, Calcium blockers, Procardia, etc)
- ▢ Yes ▢ No Antihistamines or decongestants
- ▢ Yes ▢ No Recreational drugs and/or tobacco products

12. Have you **ever** taken any of the following medications?

- ▢ Yes ▢ No Fen-Phen (fenfluramine + phentermine)
- ▢ Yes ▢ No Pondimin (fenfluramine), Redux (dexfenfluramine)
- ▢ Yes ▢ No Aredia (pamidronate), Zometa (zoledonic acid)
- ▢ Yes ▢ No Osteoporosis drugs (i.e. Fosamax, Actonel, other bisphosphonates)

13. Are you allergic or have had a bad reaction to any of the following?

- ▢ Yes ▢ No Penicillin, amoxicillin, or other antibiotics
- ▢ Yes ▢ No Sulfa drugs
- ▢ Yes ▢ No Aspirin or ibuprofen
- ▢ Yes ▢ No Local anesthetics (i.e. novocaine, lidocaine)
- ▢ Yes ▢ No Barbiturates, sedatives, etc.
- ▢ Yes ▢ No Codeine or similar pain relievers
- ▢ Yes ▢ No Latex or rubber products
- ▢ Yes ▢ No Other (please describe)

Please list all medications you are currently taking and dosages, or kindly provide a printed copy:

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I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. The information I have provided is complete and accurate.

Patient/Guardian Signature: ______________________________ Date: ______________