Grand River Dental

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MEDICAL ALERT	
PREMED	ALLERGIES
ANESTHETIC	LATEX

Client Information and History Form

In order to serve you properly, we need the following information. All information is strictly confidential.

Today's date: _____ Purpose of appointment: _____

Patient's name: _____ DOB: _____ SSN: _____

If a minor, parent/guardian name: _____ Relationship: _____

Address: _____City/ZIP: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Marital status: _____ Email address: _____

Employer name: _____ Employer address: _____

Name and phone # of someone we may contact in an emergency: _____

How did you hear of our office? _____

(The policy of this office does not permit parents in the dental operatory with their children during dental procedures.)

Patient Dental and Medical History

Name of previous dentist: _____ Address: _____

Date of last dental exam: _____ Do you require antibiotics before dental procedures? YES NO

Are you in good health? YES NO Date of last health exam: _____

Are you currently in the care of a physician? YES NO If yes, for what? _____

Name of physician: _____ Physician's phone: _____

Are you taking any prescription or over-the-counter medications? YES NO If yes, please list the drug names, why you are taking them, and the dose: _____

_____

_____

Pharmacy name: _____ Pharmacy Phone #: _____

Do you regularly take any dietary supplements or herbal medicines? YES NO If yes, do you take:

Diet/Energy supplements Echinacea Garlic Ginger Gingko Ginseng Kava St. John's Wort

Valerian Vitamin E > 400 I.U. daily Fish Oil > 3 grams daily Other (please list):_____

_____

Have you ever been treated for substance abuse or do you regularly use any recreational drugs? YES NO

Do you smoke or chew? YES NO If yes, frequency and length of use: _____

Have you been hospitalized for any surgical operation or serious illness? YES NO If yes, please explain:

_____

WOMEN ONLY: Are you pregnant or think you might be pregnant? YES NO If yes, expected due date:_____

Are you nursing? YES NO Do you take oral contraceptives YES NO Name of OB/GYN: _____

Allergies: Are you allergic to or have you had an adverse reaction to:
(CIRCLE ONE)

YES	NO	LOCAL ANESTHETICS	YES	NO	CODEINE OR OTHER NARCOTICS
YES	NO	ASPIRIN	YES	NO	PENICILLIN OR OTHER ANTIBIOTICS –
YES	NO	SULFA DRUGS			PLEASE LIST_____
YES	NO	ANY METAL (NICKEL, GOLD, ETC.)			_____
YES	NO	LATEX	YES	NO	OTHER
YES	NO	BARBITUATES, SEDATIVES, SLEEPING PILLS			PLEASE LIST _____

Client Health History – Do you have, or have you had the following? (Circle one)

YES NO Arthritis
Type: _____
YES NO Asthma
YES NO Blood transfusion
If yes, date: _____
YES NO Bleeding problems
YES NO Hemophilia
YES NO Cancer
YES NO Leukemia
YES NO Chemotherapy
YES NO Radiation
YES NO Heart trouble
YES NO Heart murmur
YES NO Angina
YES NO Artificial heart valve
YES NO Damaged heart valve
YES NO Heart attack
YES NO High blood pressure
YES NO HIV/AIDS
YES NO Low blood pressure
YES NO Pacemaker
YES NO Diabetes
Type: _____
YES NO Dry mouth
YES NO Epilepsy
YES NO Fainting spells
YES NO Seizures
YES NO G.I. Reflux
YES NO Hepatitis
Type: _____
YES NO Kidney problems
YES NO Lupus Erythematosis
YES NO Mental health disorders
YES NO Liver problems
YES NO Diarrhea (chronic)
YES NO Fibromyalgia
YES NO Artificial joint
If yes, date: _____
YES NO Dental Implants
YES NO Neurological disorders
YES NO Osteoporosis
YES NO Respiratory problems
YES NO TB
Date: _____
YES NO Severe headaches
YES NO Sexually Transmitted Diseases
YES NO Sinus trouble
YES NO Sores in the mouth
YES NO Ulcers in the mouth
YES NO Stroke
YES NO Thyroid problems
YES NO Ulcers
YES NO Anemia

If yes to any of the above, please explain:

_____

_____

_____

Authorization and 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 understand it is my responsibility to inform the dentist of any changes in my medical status. I will not hold my dentist or any other member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. 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 treatment of such dental care to third party payers and/or health practitioners. I acknowledge it is the policy of the dental office not to permit parents in the dental operatory with their children during dental procedures. I understand that I will be charged for no-show appointments or chronic cancellations, and that I must give 48 hours notice when canceling an appointment. If less than 48 hours cancellation notice a $50 per treatment hour fee will be charged. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment. I also understand that blood tests may be performed upon me if a health worker is exposed to my blood or other bodily fluids under his/her skin, in an open wound, or through a mucous membrane while treating me at this facility. I have been informed that this procedure will be discussed with me prior to its taking place. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. The fee for returned checks is $35.00

_____ Date: _____

Signature of patient or legal guardian. This form MUST be signed by a person of legal age.

Dentist's comments: _____

_____

Patient goals for treatment: _____

Patient's blood pressure: _____ Date: _____ Dentist's signature: _____