

Griffith Cosmetic & Family Dental Care

Welcome! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

Personal

Name: _____
First Last MI

Title: Dr. Mr. Mrs. Ms. Rev.

Marital Status: Married Single Divorced Separated Other

Age: _____ Birthdate: _____ Social Security#: _____

Address: _____

City State Zip

Phone (home): (____) _____ E-mail: _____
(work): (____) _____
(cell): (____) _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Phone(home):(____) _____

Relationship: _____ (work):(____) _____
(Cell):(____) _____

Employer

Occupation: _____

Name: _____ Phone: (____) _____

Address: _____

Responsible Party

Self Other, If other please fill out this portion

Name of responsible party: _____

Birthdate: _____ Social Security: _____

Relationship: _____ Address: _____

Phone :(____) _____

Dental History

Reason for today's visit: _____

Please check any of following conditions that apply:

- | | | |
|--|---|--|
| <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 | <input type="checkbox"/> sensitivity to sweets |
| <input type="checkbox"/> clicking/popping jaw | <input type="checkbox"/> broken fillings/restorations | <input type="checkbox"/> sensitivity when biting |
| <input type="checkbox"/> food collection between teeth | <input type="checkbox"/> gum/periodontal treatment | <input type="checkbox"/> sensitivity to cold |
| <input type="checkbox"/> sores/growths in your mouth | | |

Are you satisfied with the appearance of your teeth? yes no

Are you interested in whitening your teeth? yes no

Medical History

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 inter-relationship with the dentistry that you will be receiving. Thank- you for answering the following questions.

Physician: _____ Phone: (____) _____

Are you currently under the care of a physician? _____

If yes, please explain: _____

Have you **ever** had any of the following?

- | | |
|---|--|
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> bleeding/clotting disorder |
| <input type="checkbox"/> heart trouble/angina | <input type="checkbox"/> blood transfusion |
| <input type="checkbox"/> heart Attack | <input type="checkbox"/> anemia |
| <input type="checkbox"/> heart murmur/mitral valve prolapse | <input type="checkbox"/> cancer |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> stroke | <input type="checkbox"/> liver disorder |
| <input type="checkbox"/> respiratory problems | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> asthma | <input type="checkbox"/> joint replacement |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> artificial parts/prosthesis |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> endocrine disorder/thyroid problem | <input type="checkbox"/> immune system disorder |
| <input type="checkbox"/> kidney disorder | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> nervous disorder | <input type="checkbox"/> drug/alcohol problem |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> venereal disease |

Have you been informed to take a medication before visiting the dentist? _____
if yes, what medication? _____

Medications

List any medications you are currently taking: _____

Allergies

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other: _____ |

Consent / Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize Drs. Griffith and their staff to take radiographs or any other diagnostic aids deemed appropriate to make diagnosis of my dental needs. I also consent to have any and all forms of treatment, medication and therapy that may be indicated and understand the risks and benefits, as well as alternatives which will be discussed. I further authorize Drs. Griffith to use my study models and/or photographs for lectures and publications.

signature (patient or guardian)

Date

signature (Dr.Griffith)

Whom may we thank for referring you? _____