

We want to get to know you; establishing and maintaining good dental health involves knowing you as well as your teeth. Please assist us by completing the following questionnaire. All information is held in strict confidence.

PERSONAL INFORMATION

E-Mail Address _____
Name _____ Preferred Name _____
HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____ Cell Phone _____
Date of Birth _____ Social Security No. _____ Residence Telephone _____
Residence Address _____ City _____ State _____ Zip _____
Occupation _____ Place of Business _____
Business Address _____ City _____ State _____ Zip _____
Business Telephone _____ If married, Spouse's Name _____
Spouse's Occupation _____ Spouse's Business Telephone _____
Spouse's Place of Business with Address _____
Who is financially responsible for this account? Name _____ Telephone _____

INSURANCE INFORMATION

Name of Dental Insurance Co _____ Group No. _____
Policy Holder _____ Social Security No. _____ Date of Birth _____

MEDICAL INFORMATION

Do you consider yourself to be in good health? Yes No If no, why not? _____
Are you under the care of a physician now? Yes No If yes, for what reason? _____
Are you taking any medications? Yes No If yes, what? _____
Do you have any allergies? Yes No If yes, to what? _____
Are you in a high risk group for AIDS or Hepatitis? Yes No

Please circle any of the following that you have had:

Diabetes	Rheumatic Fever	Heart Condition	High Blood Pressure	Hepatitis
Arthritis	Asthma	Tumor or Cancer	Radiation Treatment	Tuberculosis
Blood Disorder	HIV	Epilepsy	Liver Disease	Kidney Disease
Hearing Disorder	Joint Replacement	Blood Transfusion and Year _____		

Woman – Are you pregnant? Yes
Have you been hospitalized or had surgery? Yes No If yes, when and why? _____
Name of your physician _____ Telephone _____

DENTAL HISTORY

What has prompted you to come for dental care at this time? _____
How long has it been since your last thorough dental exam? _____
Are you happy with your past dental care? _____
Have you had any bad experiences or are you nervous about dental treatment? _____
Have you ever had orthodontics? Yes No If yes, please give your age at the time of treatment and orthodontist's name and location. _____
Have you been shown how to properly care for your teeth? _____
How do you feel about your teeth? _____
How long do you plan to have your teeth? _____
How do you feel about dentures? _____

RELEASE AND ASSIGNMENT

I hereby authorize Grandview Dental Care, Inc. to speak with any healthcare practitioner who has treated, or is treating the patient about any past or present medical or dental diagnosis, treatment or condition. This authorization includes the release of any dental or medical records to Grandview Dental Care, Inc., reasonably deemed necessary. This authorization will remain valid until revoked by me in writing. I also hereby authorize that my insurance be paid directly to the doctor unless otherwise noted and I authorize the doctor to release any information required to process my claim. I acknowledge that I am financially responsible for all non-covered services. I understand that whoever brings my child/children to their visit must be prepared to make applicable payment or co-payment at the time of service.

SIGNATURE _____ DATE: _____