**GRANDVIEW DENTAL CARE** 1220 Grandview Avenue, Columbus, OH 43212 Telephone (614)486-7378
**Visit us at www.grandviewdentalcare.com**

**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 No

Have you been hospitalized or had surgery? Yes No If yes, when and why? ________________________________

I have been told I snore or stop breathing during my sleep (never, rarely, occasionally, frequently) please circle one

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

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? _____________________________________________________________________________

**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: ______________________________