William T. Griffin, DDS, PC Kimberly J. Greenwell, DMD Sonia Tao-Yi, DDS

Patient Information

Patient Name: _____ **Date**:_____
Last First MI (Preferred Name)

Gender: Male Female **Family Status**: Single Married Other

Social Security #:_____ **Birth Date**:_____

Phone (Home)_____ (Work)_____ (Cellular) _____**E-mail** _____

Please check the following payment method you prefer: ☐ Cash ☐ Personal Check ☐ Credit Card

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit:_____ Reason for today's visit: _____

Please check all conditions that you have now or have had in the past:

☐ Abnormal Bleeding
☐ AIDS or HIV+
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Cancer - Chemotherapy/Radiation
☐ Diabetes - Type I or II
☐ Eating disorder
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hepatitis/Jaundice
☐ Codeine Allergy
☐ Osteoporosis
☐ Kidney Disease

Cardiovascular Disease. Please specify below:
☐ Angina
☐ Arteriosclerosis
☐ Artificial heart valves
☐ Congenital heart defects
☐ Congestive heart failure
☐ Coronary artery disease
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ ***Pregnant Now***
Due date:_____
☐ Respiratory Problems
☐ Sinus Problems
☐ GERD/Heartburn
☐ Stroke
☐ Thyroid condition
☐ Tobacco Use
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Sexually Transmitted Disease
☐ Penicillin Allergy
☐ Latex Allergy

☐ Other Allergies
☐ Are you taking, or have you taken:
☐ Pondimin, Redux, or Phen-fen?
☐ Fosamax, Boniva, Actonel or other bisphosphonates?
☐ Do you use drugs or other substances for recreational purposes? If yes, please list:

☐ Has a Physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

- Please list any medications (prescription, over the counter and herbal supplements) that you are currently taking.
_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you snore? ☐ Yes ☐ No
- Has anyone reported that you choke or gasp for air while you are sleeping? ☐ Yes ☐ No
- Do you now or have you ever used CPAP? ☐ Yes ☐ No
- Would you like to discuss your options for teeth whitening? ☐ Yes ☐ No
- Would you be agreeable to the Doctor praying with you or for you? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ___Another patient, friend ___Another patient, relative
___Another Doctor ___Dental Office Staff ___Internet ___Newsletter ___Other
Name of person referring you to our practice_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Benefits Information

Primary

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Benefit Plan Name and Address: _____

_____

Secondary

Due to the unpredictable coverage of secondary dental benefits, we do not file or estimate these benefits.
We will assist you with the necessary paperwork to file secondary benefits.

Consent for Services

I am aware that payment for dental services rendered to me, or at my request, by the doctor is expected at the time of service unless other arrangements are made in advance.

If I have dental benefits, I am aware that this office will assist me by preparing forms and submitting necessary documents at no charge to me. However, I realize that I, not my benefit company, am ultimately financially responsible for treatment that I receive. If my dental benefit company does not respond within 60 days, I agree to accept immediate responsibility for any unpaid balance.

I realize that accounts which are not paid within 30 days after being billed are subject to a 1% per month (12% per annum) finance charge on the unpaid balance. In addition, accounts unpaid after 90 days may be turned over to a collection agency, and I will be responsible for the costs of collection.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian