Gruendel & Associates :Dentistry

Registration and History

Patient Information

Date _____

SS/HIC/Patient ID# _____

Patient Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birth date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birth date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies), and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Phone Numbers

Home Phone _____

Work Phone _____

Mobile Phone _____

Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken filings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as ''fen-phen?" These include combinations of Ionimin, Adioex, Fastin (brand names of phentermine), Poncimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Hepatitis Type	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding abnormally, with		Jaundice	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Have you ever had any serious	
Circulatory Problems	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	illness not listed above?	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	If yes, please explain: _____	
Cortisone Treatments	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	**Women:**	
Emphysema	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	If yes, due date: _____	
Epilepsy	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Are you taking birth control pills?	☐ Yes ☐ No

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____
_____

Comments _____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

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 this office of any changes in my medical status.

Signature _____ Date _____

Typing your name here constitutes a legal signature