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): (_____)_____
(work): (_____)_____
(cell): (_____)_____ **E-MAIL:** _____

IN CASE OF EMERGENCY, CONTACT
Name:_____ Phone(home):(____)_____
(work):(____)_____
Relationship: _____ (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:

☐ bad breath	☐ grinding teeth	☐ sensitivity to hot
☐ bleeding gums	☐ loose teeth	☐ sensitivity to sweets
☐ clicking/popping jaw	☐ broken fillings/restorations	☐ sensitivity when biting
☐ food collection between teeth	☐ gum/periodontal treatment	☐ sensitivity to cold
☐ 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?

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

- ☐ Aspirin
- ☐ Barbiturates(sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Sulfa
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ 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?_____