WELCOME

Gordon K. Green D.D.S.
Cosmetic & Comprehensive Dentistry
"Changing Faces, Changing Lives."

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We Welcome New Patients

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximun oral health.

Please fill out these forms completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Name: _____

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____

_____

Email: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Drivers Lincense #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & When are the best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Dental Appointment: _____

2 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insusrance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insusrance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's SS#: _____

Insured's Employer: _____

3 Spouse / Parent Information

His/Her Name: _____

Employer: _____

Work Ph #: _____ Ext: _____ SS#: _____

Birthdate: ___/___/___ Drivers Lic #: _____

Person Responsible for Account: _____

Work Ph #: _____ Ext: _____ Home Ph #: _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____ Drivers Lic #: _____

4 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: _____ Last Visit Date: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

Work Ph #: _____ Home Ph #: _____

Form continued on back

5 Medical History

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one or attach complete list: _____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems? (Please circle Y for Yes or N for No)

Y N Heart Attack	Y N Depression/Mental Health
Y N Stroke	Y N Epilepsy / Seizures / Fainting
Y N Cancer	Y N Diabetes
Y N Chemotherapy	Y N Tuberculosis (TB)
Y N Radiation Treatment	Y N Drug Abuse
Y N Heart Murmur	Y N Alcohol Abuse
Y N Heart Surgery / Pacemaker	Y N Fever Blisters
Y N Mitral Valve Prolapse	Y N Hemophilia / Abnormal Bleeding
Y N Rheumatic Fever	Y N Ulcers
Y N HIV+ / AIDS	Y N Colitis
Y N Shingles	Y N Congenital Heart Defect
Y N Kidney Problems	Y N Anemia
Y N Artificial Bones / Joints	Y N Arthritis
Y N Artificial Valves	Y N Asthma
Y N Difficulty Breathing	Y N Emphysema
Y N Sinus Problems	Y N Hepatitis
Y N High Blood Pressure	Y N Blood Transfusion
Y N Low Blood Pressure	Y N Severe / Frequent Headaches
Y N Glaucoma	

Please list any medical condition that we should be aware of:

_____

_____

Do you have any artificial joint replacements? _____

Do you need to take antibiotics prior to treatment? _____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Sulfa
Y N Aspirin	Y N Dental Anesthetics	Y N Latex
Y N Erythromycin	Y N Codeine	Y N Other

Please list any other drugs that you are allergic to: _____

_____

_____

Have you been hospitalized in the last 5 years? Y N Why?

_____

_____

6 Dental History

Have you traveled outside of the U.S. in the last 6 months? If so when and where? _____

_____

Why have you come to the dentist today: _____

_____

_____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ NO

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

DO YOU SMOKE ❑ Yes ❑ No

DO YOU CHEW ❑ Yes ❑ No

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I also authorize this office to arrange credit for me if necessary. If my account should become delinquent, I will be responsible for all expenses involved in collection efforts, including attorney's fees, court costs, and collection agency fees of 40%.

_____

Signature **Date**