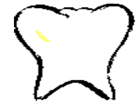
GR Family Dental



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. We look forward to working with you in maintaining your dental health.

Patient Information

Name____ Date of Birth__________ Age __________
Last First Middle

Address____ Apt #________ Sex □ M □ F

City____ State_____________ Zip Code_____________

Home Phone ( )___________________________Cell Phone ( )__________________________

Social Security Number______________________ E-Mail Address_____________________________

□ Single □ Married □ Separated □ Divorced □ Widowed □ Minor

Employer/School_______________________________ Occupation__________________________________

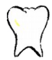
Employer/School Address______________________________ Employer/School Phone________________

Spouses Name______________________________

Name and Age of any children_____________________ ____________________ ___________________

Who may we thank for referring you?____

In case of emergency who should be notified?_________________________ Phone ( )________________



Primary Insurance

Person Responsible for Account___________________________________ Relationship to Patient___________
Last Name First Name

Soc. Sec. #_________________________ Date of Birth ________________

Subscriber's Employer_____________________________________ Employers Phone ( )_______________

Employer's Address_________________________________ City_____________ State_____ Zip___________

Insurance Company__________________________________ Group # __________________

Secondary Insurance

Is patient covered by additional Insurance? □ Yes □ No

Subscriber's Name__________________________________ Relationship to Patient _________________

Soc. Sec. #________________________ Date of Birth _________________

Subscriber's Employer____________________________________ Employer's Phone ( )___________

Employer's Address_______________________________ City______________ State____ Zip ________

Insurance Company _______________________________ Group # __________________

Patient Health Record

Physician's Name____ Last Date Seen ___________________________

Former Dentist____ Date of Last Check-Up____________________

Do You Now Have, or have you ever had any of the following?

	Yes	No		Yes	No
Heart Disease	□	□	High Blood Pressure	□	□
Rheumatic Fever	□	□	Ulcers	□	□
Tuberculosis	□	□	Diabetes	□	□
Positive HIV	□	□	Epilepsy	□	□
Heart Murmur	□	□	Anemia	□	□
Hepatitis	□	□	Tumors or Growths	□	□
Kidney Disease	□	□	Prolonged Bleeding	□	□
Chest Pains	□	□	Fainting Spells	□	□
Artificial Joint Replacement	□	□	Latex Allergy	□	□
Asthma	□	□	Pacemaker	□	□

Yes	No	
□	□	Are you now being treated by a physician or any health care professional? If so please explain ____
□	□	Are you allergic, or have had any unusual reaction to any drug? If so what drug? ____
□	□	Have you ever had any adverse reaction to Novocain?
□	□	Are you taking any blood thinning medication? What kind?______________________
□	□	Are you taking any drugs or medications? If so, what and how much? a.__________________ b.__________________ c.________________ d.________________
□	□	Do your gums bleed easily, feel tender or irritated?
□	□	Are your teeth sensitive to: □ Hot □ Cold □ Sweets □ Pressure
□	□	Do you grind or clench your teeth?
□	□	Do you have popping or clicking noises when you chew?
□	□	Do you have headaches, earaches, or jaw aches?
□	□	Is there anything in your medical history that the Doctor should be made aware of?
□	□	Do you smoke? How much/often?____

FEMALES:

Yes	No	
□	□	Are you pregnant? If so, what is your due date? ______________________

****HIPAA AUTHORIZATION**:**

**I authorize GR Family Dental to disclose my dental records and information to:____________________________

____Relationship To Patient:________________________________

Can our office Leave a message on a voicemail YES___ NO___*With a Person YES___NO____

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor. Also, if I have any questions about any procedure, I may ask the doctor or any staff member at any time. I authorize treatment of the person named above and agree to pay all fees and charges at the time of treatment, unless credit arrangements are agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of the billing date. In the event legal action should become necessary to collect and unpaid balance due for dental treatment rendered to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determined proper, I/we also agree that the matter be litigated in the 62B District Court (Kentwood). It is also agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and proceeds of insurance are assigned to this office where applicable, but without their assuming responsibi[illegible]or the collection thereof. The above information is for the purpose if obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

Signature____ Date_________________________