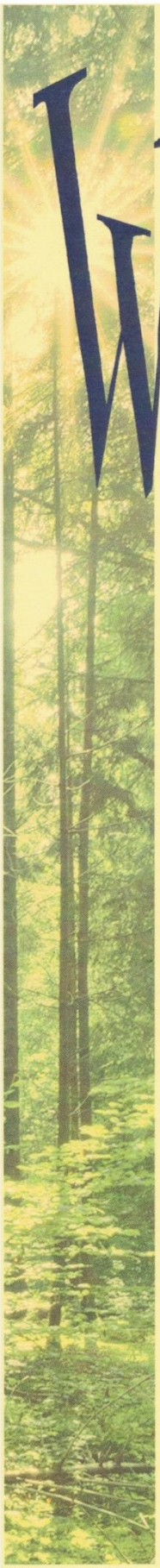

DR. ANTHONY GRAY, DDS • 1045 PEERLESS CROSSING • CLEVELAND, TENNESSEE 37312 • 423.478.5425

Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Name:_____ **Birth Date:**_____ **Date:**_____

Are you under a physician's care now? ..... ☐ Yes ☐ No
Have you ever been hospitalized or had a
major operation? ..... ☐ Yes ☐ No If Yes _____
Have you ever had a serious head or neck injury?..... ☐ Yes ☐ No If Yes _____
Have you ever taken any medications for your bones
ie: Fosamax, Boniva, Actonel, or any other ..... ☐ Yes ☐ No If Yes _____
Do you use tobacco?..... ☐ Yes ☐ No
Are you taking any medications, pills, supplements/
vitamins, or drugs, including OTC?..... ☐ Yes ☐ No If Yes _____

Are you currently taking any blood thinners, including aspirin?..... ☐ Yes ☐ No
Has a physician or previous dentist recommended that you take
antibiotics prior to your dental treatment?..... ☐ Yes ☐ No

Women: Are you.... ☐ Pregnant ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Yes ☐ No Aspirin	☐ Yes ☐ No Penicillin	☐ Yes ☐ No Codeine	☐ Yes ☐ No Acrylic	☐ Other
☐ Yes ☐ No Metal	☐ Yes ☐ No Latex	☐ Yes ☐ No Sulfa Drugs	☐ Yes ☐ No Local Anesthetics	_____

Do you use controlled substances?..... ☐ Yes ☐ No
Are you currently under a physician's care for pain management?... ☐ Yes ☐ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Angina	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No
Hives or Rash	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Hypoglycemia	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Tumors/Growths	☐ Yes ☐ No	Cold sores/Fever Blister	☐ Yes ☐ No
Pain in Jaw Joints	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Congenital Heart	
Parathyroid Disease	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Disorder	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No
If yes, which type_____		Anemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Fainting Spells/Dizzy	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Heart Attack/Failure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Alzheimer's Disease	☐ Yes ☐ No
Heart Trouble/Disease	☐ Yes ☐ No	If yes, which type _____		STD	☐ Yes ☐ No
				If yes, which type_____	

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____
Name of Previous Dentist and Last Exam _____
Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____
Signature of Patient, Parent, or Guardian Date