Kimberly J. Greenwell, DMD | William T. Griffin, DDS, P.C. | Sonia Tao-Yi, DDS

Patient Information

Patient Name: ____ **Date**:___________
Last First MI (Preferred Name)

Gender: Male Female **Family Status**: Single Married Other

Social Security #:____________________________________ **Birth Date**:_________________

Phone (Home)_____________ (Work)____________ (Cellular) ___________**E-mail** ____________________

Please check the following payment method you prefer: ☐ Cash ☐ Personal Check ☐ Credit Card

Address: ______________________________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit:___________________ Reason for today's visit: _______________________________

Please check all conditions that you have now or have had in the past:

☐ Abnormal Bleeding
☐ AIDS or HIV+
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Cancer - Chemotherapy/Radiation
☐ Diabetes - Type I or II
☐ Eating disorder
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hepatitis/Jaundice
☐ Codeine Allergy
☐ Osteoporosis
☐ Kidney Disease

Cardiovascular Disease. Please specify below:
☐ Angina
☐ Arteriosclerosis
☐ Artificial heart valves
☐ Congenital heart defects
☐ Congestive heart failure
☐ Coronary artery disease
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ ***Pregnant Now***
Due date:_________
☐ Respiratory Problems
☐ Sinus Problems
☐ GERD/Persistent Heartburn
☐ Stroke
☐ Tobacco Use
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Sexually Transmitted Disease
☐ Penicillin Allergy
☐ Latex Allergy

☐ Other Allergies
☐ Are you taking, or have you taken:
☐ Pondimin, Redux, or Phen-fen?
☐ Fosamax, Boniva, Actonel or other bisphosphonates?
☐ Do you use drugs or other substances for recreational purposes? If yes, please list:

☐ Has a Physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

- Please list any medications (prescription, over the counter and herbal supplements) that you are currently taking.
  ____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: _____________________________________ Phone: _______________
- Do you snore? ☐ Yes ☐ No
- Has anyone reported that you choke or gasp for air while you are sleeping? ☐ Yes ☐ No
- Do you now or have you ever used CPAP? ☐ Yes ☐ No
- Would you like to discuss your options for teeth whitening? ☐ Yes ☐ No
- Would you be agreeable to the Doctor praying with you or for you? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ___Another patient, friend ___Another patient, relative
___Another Doctor ___Dental Office Staff ___Internet ___Newsletter ___Other
Name of person referring you to our practice____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): _______________ (Work): _______________ Ext: _____ Best time to call: ___________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:__________________________________ Occupation: ___________________________

Address: ____

Street City, State Zip Code Phone

Dental Benefits Information

Primary

Name of Subscriber: ____ Is subscriber a patient? ☐ Yes ☐ No

Last First MI

Subscriber's Birth Date: _______________ ID #: ___________________ Group #: ________________

Subscriber's Address: ____

Street City State Zip Code

Subscriber's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Dental Benefit Plan Name and Address:____

____

Secondary

Due to the unpredictable coverage of secondary dental benefits, we do not file or estimate these benefits.
We will assist you with the necessary paperwork to file secondary benefits.

Consent for Services

I am aware that payment for dental services rendered to me, or at my request, by the doctor is expected at the time of service unless other arrangements are made in advance.

If I have dental benefits, I am aware that this office will assist me by preparing forms and submitting necessary documents at no charge to me. However, I realize that I, not my benefit company, am ultimately financially responsible for treatment that I receive. If my dental benefit company does not respond within 60 days, I agree to accept immediate responsibility for any unpaid balance.

I realize that accounts which are not paid within 30 days after being billed are subject to a 1% per month (12% per annum) finance charge on the unpaid balance. In addition, accounts unpaid after 90 days may be turned over to a collection agency, and I will be responsible for reasonable collection fees.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ___________ Relationship to Patient: _________________

Signature of patient, parent or guardian