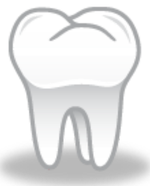
GR Family Dental



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.

New 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: _____________________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Employer/School: ____________________________ Occupation: _________________________

Employer/School Address: _____________________ Employer/School Phone: ______________

Spouse's Name: ______________________ Who referred you? ___________________________

Name and Age of Children: ___________________ _____________________ ______________

Emergency Contact: _____________________________ Phone Number: ___________________

Primary Insurance

Person Responsible for Account: _______________________ Relationship to Patient: __________

Social Security Number: _______________________________ Date of Birth: ________________

Subscriber's Employer: _________________________ Employer's Phone: __________________

Employer's Address: ________________________ City: ___________ State: _____ Zip: ______

Insurance Company: _____________________________ Group Number: __________________

Secondary Insurance

Is the patient covered by additional insurance? ☐ Yes ☐ No

Person Responsible for Account: _______________________ Relationship to Patient: _________

Social Security Number: _______________________________ Date of Birth: ________________

Subscriber's Employer: _________________________ Employer's Phone: __________________

Employer's Address: _______________________ City: ___________ State: _____ Zip: _______

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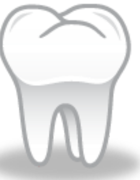


Insurance Company: ______________________________ Group Number: ___________________

Medical History

Physician's Name: ______________________________ Phone Number: _________________________

Are you currently under a physician's care for any medical issues? Please explain:

____

Do you have/had you ever had any of the following? Check yes or no:

Yes	**No**		**Yes**	**No**		**Yes**	**No**	
☐	☐	Heart Disease	☐	☐	ADHD/ADD	☐	☐	COPD/Emphysema
☐	☐	Congenital Heart Disease	☐	☐	Snoring	☐	☐	Congestive Heart Failure
☐	☐	Chest Pains	☐	☐	Use a CPAP	☐	☐	Ulcers
☐	☐	Hepatitis	☐	☐	Sleep Issues	☐	☐	Tumors/Growths
☐	☐	HIV Positive/AIDS	☐	☐	Restless Legs	☐	☐	Blood Clotting Issues
☐	☐	Rheumatic Fever	☐	☐	GERD/Acid Reflux	☐	☐	Blood Disorders
☐	☐	Tuberculosis	☐	☐	Tonsils Removed	☐	☐	Mental Disorders
☐	☐	Kidney Disease	☐	☐	Immune Disorder	☐	☐	Headaches
☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Ear aches

☐ ☐ Have you had any serious illnesses or operations? If yes, please explain:

____

☐ ☐ Pacemaker/Stent. If yes, when? ____

☐ ☐ High Blood Pressure. If yes, are you taking medications for it? ____________________

☐ ☐ Diabetes. If yes, what was your most recent Hba1c? ______________________________

☐ ☐ Fainting Spells. If yes, what causes them? ____________________________________

☐ ☐ Epilepsy. If yes, what causes the seizures? ____________________________________

☐ ☐ Cancer. If yes, what treatment did you receive/when? ____________________________

☐ ☐ Food/dust/seasonal Allergies? If yes, which? __________________________________

☐ ☐ Allergy to local anesthetic like Lidocaine? If yes, which? ________________________

☐ ☐ Artificial joints? If yes, what joints/when? ____________________________________

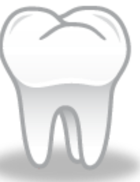
☐ ☐ Do you use tobacco? What form? ___________ How much? ______________________

☐ ☐ Are you pregnant or nursing? Which? ______________ If pregnant, due date: ____________

☐ ☐ Are you taking any blood thinners? If yes, what? _____________________________

☐ ☐ Are you taking any medications currently (prescription and/or over the counter?) Please list them:

________________ ____________________ __________________ _________________



______________ ________________ _______________ ______________

Do you have **allergies** to any of the following?

☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Codeine ☐ Narcotics ☐ Latex ☐ Other: _________ ☐ None

Dental History

Name of previous Dentist: ________________________________ Phone number: ________________

When was your last dental visit? ___________________ Did they take x-rays? ___________________

Do you experience any of the following? Check yes or no:

Yes	No		Yes	No	
☐	☐	Mouth breathing	☐	☐	Bleeding Gums
☐	☐	Jaw Pain	☐	☐	Bad Breath
☐	☐	Popping/clicking noises in ear	☐	☐	Recurrent Mouth Sores
☐	☐	Dental Anxiety	☐	☐	Toothache

☐ ☐ Grinding/clenching teeth. If yes, do you wear a bite splint? ______________________________

☐ ☐ Sensitive teeth/gums. If yes, to what? ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

☐ ☐ Do you need to be pre-medicated for dental appointments?

☐ ☐ Are you currently having any dental pain or concerns? If yes, please explain:

____

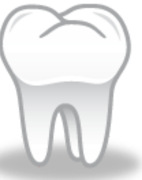
☐ ☐ Have you had any serious trouble associated with previous dental treatment? If yes, please explain:

____

☐ ☐ Is there anything in your medical or dental history not listed on this form that the Doctor should be made aware of? If yes, please explain: ____

How often do you brush? _____________________________ Floss? ___________________________

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 an 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 all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. The above information is for the purpose of 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**: __________________________