

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush?	_____	_____
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss?	_____	_____
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Sours?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL HEALTH HISTORY:

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

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urine more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____		
If so, please describe: _____		

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies _____	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Notes: _____

_____ Date: _____

Women

	Yes	No
Are you taking contraceptives or other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____		

Notes: _____

Patient/Parent Signature: _____

Dentist Initial: _____



DAVID J. GREER D.D.S.

FINANCIAL POLICY

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

INSURED PATIENTS:

- Although your insurance may assist you with partial payment or your treatment, the estimated portion that is not covered, is due when services are rendered.
- As a courtesy to our patients, we will file your dental insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.

WE DO NOT FILE MEDICAL INSURANCE

Information is available upon request for third-party financing through Care Credit.

- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance on my account
- I authorize all insurance benefits paid directly to David J. Greer DDS
- If payment by the insurance company is made to the insured, I agree to endorse or have the insurance endorse the benefits check to David J. Greer DDS or make payment immediately to David J. Greer DDS.
- I authorize the release of information to my insurance company, attorney, or legal representative to obtain reimbursement of any claim(s) or for other reasons.
- A finance charge of 1.5% will begin to accrue after 90 days from the date of service on the unpaid balance of my account even though insurance may be pending.
- If agree to pay any fees incurred due to returned checks.
- A \$50.00 charge will be incurred for failure to give a (48) hour notice for cancellations.
- I understand and agree that if the amounts for which I am responsible become delinquent, I will pay for all costs associated with the collection process. This includes but would not be limited to collection fees, attorney fees and court costs.
- I authorize this office to discuss my account with a spouse, parent, step parent, subscriber of any insurance that is requested to be filed on my behalf or responsible party no matter if I am considered legally to be an adult.

SIGNATURE OF RESPONSIBLE PARTY

DATE

David J. Greer D.D.S. PLLC
6320 Southwest Blvd Ste 112, Fort Worth, TX 76109
Phone (817)731-2821

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a
copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

=====
=====
For Office Use Only
=====

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgment could not be obtained because:

- Individual refused to sign.
- Communications barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify)

