# DAVID B. GREGORY D.D.S., P.A.

Registration & Medical History

Today's Date \_\_\_\_\_

Welcome to David B. Gregory D.D.S., P.A.! We're pleased to have the privilege of serving you. The benefits of a healthy, beautiful smile are immeasurable and our goal will be to enable you to obtain the strong teeth and attractive smile that you deserve. Please take a moment to complete this form so that we have the information necessary to provide the best care possible for you. Thank you.

# ABOUT YOU

SS#	_ 🗌 Female 🗌 Male
Email Address:	
State Zip	
Business Phone	
Birthdate///////	Age:
Name of Spouse	
Spouse's Employer	
	Email Address:

#### **EMERGENCY INFORMATION**

Person to contact	Relationship
Phone	

I give permission for David B. Gregory D.D.S. to share my medical and account information with:

### **DENTAL INSURANCE**

Name of policy holder						
Relationship to policy holder:  Self Spouse Child Other						
Policy holder's ID/Social Security Number						
Insurance Company						
Group#						
Policy holder's birth date///						
Policy holder's employer						

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to David B Gregory, DDS, PA. *Initials:*\_\_\_\_\_\_

## **MEDICAL HISTORY**

Name of personal physician:       Phone:         Have you had any serious health problems in the last five years?       Ves       No       If yes, please explain:         (For women) Are your currently pregnant?       Ves       No       If yes, how many months?         Please list prescription medication       Are you currently taking any of the following:       Bisphosphonates (Fosamax, Actonel, Boniva, Reclast)         Please check if you're allergic to any of the following:       Codeine/other narcotics         Deniclini/other antibiotics       Aspirin       Latex sensitivity         I local anesthetics       Sulfa drugs       Codeine/other narcotics         Peniclini/other antibiotics       Aspirin       Latex sensitivity         I doine       Other       Do you have, or have you had, any of the following:         Artificial Heart Valve       Cortisone Medicine       Epilepsy or Seizures         Mitral Valve Prolapse       Congenital Heart       Stomad/Intestinal Disease       Epilepsy or Seizures         Rheumatic Fever       Disorder       Faniting Spelis/Dizziness       Epilepsy or Seizures         Attificial Joint       Pace Maker       Hive or Rash       Cancer         Attificial Joint       Pace Maker       Hives or Rash       Cancer         Attificial Joint       Pace Maker       Hives or Rash       Canc						
(For women) Are your currently pregnant?       Yes       No       If yes, how many months?         Please list prescription medication	Name of personal physician:_		Phone:			
Please list prescription medication         Are you currently taking any of the following:         Blood Thinners (coumadin, plavix)       Bisphosphonates (Fosamax, Actonel, Boniva, Reclast)         Please check if you're allergic to any of the following:         Local anesthetics       Glifd drugs         Penicillin/other antibiotics       Aspirin         Lotal anesthetics       Glifd drugs         Artificial Heart Valve       Acid Reflux         Penicillin/other antibiotics       Cortisone Medicine         Mitral Valve prolapse       Congenital Heart         Stomach/Intestinal Disease       Epilepsy or Seizures         Phepatities B or C       Heart Attack/Failure         Hepatitis B or C       Heart Attack/Failure         AtDS/HIV Positive       Heart Murmur         Hapatitis B or C       Heart Murmur         Hapatitis B or C       Heart Murmur         Hapatitis A       Frequent Cough         Storing       Heat Murmur         Hapatitis B or C       Heart Thoule/Disease         Stroke       Emphysema       Tumors or Growths         TMU/Jaw Pain       Heapatitis A       Frequent Cough         Headaches       Stroke       Emphysema         Blood Disease       Cold Sores/Fever Bisters       Lung Disease	Have you had any serious hea	alth problems in the last five year	rs? 🗌 Yes 🗌 No 🛛 If yes, please ex	kplain:		
Are you currently taking any of the following:         Blood Thinners (currently taking any of the following:         Correct Structure         Plase check if you're allergic to any of the following:         Local anesthetics       Sulf a drugs         Pensicillin/other antibiotics       Aspirin         Local anesthetics       Cortisone Medicine         Other       Other         Do you have, or have you had, any of the following:       Cortisone Medicine         Artificial Heart Valve       Acid Reflux       Cortisone Medicine         High Blood Pressure       Chest Pains       Ulcers       Convulsions         Mitral Valve Prolapse       Congenital Heart       Stomach/Intestinal Disease       Drug Addiction         Hapatitis B or C       Heart Attack/Failure       Anaphylaxis       History of Tobacco Use         Artificial Joint       Pace Maker       Hives or Rash       Cancer         Storing       Heart Trouble/Disease       Asthma       Chemotherapy         Dry Mouth       Low Blood Pressure       Breaution Treatments         Headaches       Stroke       Emphysema       Tumors or Growths         Blood Tinsfusion       Glaucoma       Sinus Trouble       Diabetes - Type I or II         Excessive Bleeding       Shingles       Swelling of L	(For women) Are your current	tly pregnant? 🗌 Yes 🗌 No 🛛 I	f yes, how many months?			
Blood Thinners (coumadin, plavix)       Bisphosphonates (Fosamax, Actonel, Boniva, Reclast)         Please check if you're allergic to any of the following:       Codeine/other narcotics         Denvicibility of the ant Valve       Aspirin         Latex sensitivity       Latex sensitivity         I odine       Other         Do you have, or have you had, any of the following:       Cortisone Medicine         Artificial Heart Valve       Acid Reflux       Cortisone Medicine         High Blood Pressure       Chest Pains       Ulcers       Convulsions         Mitral Valve Prolapse       Congenital Heart       Stomach/Intestinal Disease       Epilepsy or Seizures         Rheumatic Fever       Disorder       Fainting Spells/Dizziness       Drug Addiction         Hepatitis B or C       Heart Murmur       Hay Fever       Psychiatric Care         Attificial Joint       Pace Maker       Hives or Rash       Cancer         Snoring       Heart Trouble/Disease       Stomak       Cancer         TM/Jaw Pain       Lopatitis A       Frequent Cough       Kidney Problems         Blood Disease       Cold Sores/Fever Bilsters       Lung Disease       Liver Disease         Leukemia       Herpets       Swelling of Limbs       Arthritis/Gout         Blood Disease       Cold Sores	Please list prescription medica	ation				
Image: Solida drugs       Codeine/other narcotics         Pencillin/other antibiotics       Aspirin       Latex sensitivity         Iodine       Other       Other         Do you have, or have you had, any of the following:       Interview of the following:       Cortisone Medicine         High Blood Pressure       Chest Pains       Ulcers       Convulsions         Mitral Valve Prolapse       Congenital Heart       Stomach/Intestinal Disease       Epilepsy or Seizures         Interview of the ext Attack/Failure       Anaphylaxis       History of Tobacco Use         AIDS/HIV Positive       Heart Attack/Failure       Anaphylaxis       History of Tobacco Use         Artificial Joint       Pace Maker       Hives or Rash       Cancer         Snoring       Heart Trouble/Disease       Asthma       Chemotherapy         Py Mouth       Low Blood Pressure       Brequent Cough       Kidney Problems         Headaches       Stroke       Emphysema       Tumors or Growths         Blood Disease       Cold Sores/Fever Blisters       Lung Disease       Liver Disease         Leukemia       Herpes       Tuberculosis       Renal Dialysis         Blood Transfusion       Glaucoma       Sinus Trouble       Diabetes - Type I or II         Excessive Bleeding       Shingles						
Artificial Heart Valve       Actid Reflux       Cortisone Medicine         High Blood Pressure       Chest Pains       Ulcers       Convulsions         Mitral Valve Prolapse       Congenital Heart       Stomach/Intestinal Disease       Epilepsy or Seizures         Interview       Disorder       Fainting Spells/Dizziness       Drug Addiction         Hepatitis B or C       Heart Attack/Failure       Anaphylaxis       History of Tobacco Use         AIDS/HIV Positive       Heart Murmur       Hay Fever       Psychiatric Care         Of thifticial Joint       Pace Maker       Hives or Rash       Cancer	<ul> <li>Local anesthetics</li> <li>Penicillin/other antibiotics</li> </ul>	Sulfa drugs	Codeir			
I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: Date of last hygiene cleaning// (For New Patients Only) I would like to learn more about: Orthodontics Orthodontics Bridges Cosmetic Dentistry Implants Veneers APPOINTMENT CANCELLATION POLICY In order that we do not have to go to a system of charging our hygiene/cleaning patients for missed or broken appointments, we ask that you give a minimum of 24 hours notice if cancelling or rescheduling is absolutely necessary.	<ul> <li>Artificial Heart Valve</li> <li>High Blood Pressure</li> <li>Mitral Valve Prolapse</li> <li>Rheumatic Fever</li> <li>Hepatitis B or C</li> <li>AIDS/HIV Positive</li> <li>Artificial Joint</li> <li>Snoring</li> <li>Dry Mouth</li> <li>Headaches</li> <li>TMJ/Jaw Pain</li> <li>Blood Disease</li> <li>Leukemia</li> <li>Blood Transfusion</li> <li>Excessive Bleeding</li> <li>Hemophilia</li> </ul>	<ul> <li>Chest Pains</li> <li>Congenital Heart Disorder</li> <li>Heart Attack/Failure</li> <li>Heart Murmur</li> <li>Pace Maker</li> <li>Heart Trouble/Disease</li> <li>Low Blood Pressure</li> <li>Stroke</li> <li>Hepatitis A</li> <li>Cold Sores/Fever Blisters</li> <li>Herpes</li> <li>Glaucoma</li> <li>Shingles</li> <li>Alzheimer's Disease</li> </ul>	<ul> <li>Acid Reflux</li> <li>Ulcers</li> <li>Stomach/Intestinal Disease</li> <li>Fainting Spells/Dizziness</li> <li>Anaphylaxis</li> <li>Hay Fever</li> <li>Hives or Rash</li> <li>Asthma</li> <li>Breathing Problem</li> <li>Emphysema</li> <li>Frequent Cough</li> <li>Lung Disease</li> <li>Tuberculosis</li> <li>Sinus Trouble</li> <li>Swelling of Limbs</li> <li>Thyroid Disease</li> </ul>	<ul> <li>Convulsions</li> <li>Epilepsy or Seizures</li> <li>Drug Addiction</li> <li>History of Tobacco Use</li> <li>Psychiatric Care</li> <li>Cancer</li> <li>Chemotherapy</li> <li>Radiation Treatments</li> <li>Tumors or Growths</li> <li>Kidney Problems</li> <li>Liver Disease</li> <li>Renal Dialysis</li> <li>Diabetes - Type I or II</li> <li>Arthritis/Gout</li> <li>Bruise Easily</li> </ul>		
I would like to learn more about:  Orthodontics  Mhitening  Mhitening  Bridges  Cosmetic Dentistry  Implants  Veneers  APPOINTMENT CANCELLATION POLICY In order that we do not have to go to a system of charging our hygiene/cleaning patients for missed or broken appointments, we ask that you give a minimum of 24 hours notice if cancelling or rescheduling is absolutely necessary.	I agree to have my blood test	ed for blood-borne diseases to in				
Orthodontics       Whitening       Bridges         Cosmetic Dentistry       Implants       Veneers         APPOINTMENT CANCELLATION POLICY       In order that we do not have to go to a system of charging our hygiene/cleaning patients for missed or broken appointments, we ask that you give a minimum of 24 hours notice if cancelling or rescheduling is absolutely necessary.	Date of last hygiene cleaning_	///	(For New Patients Only)			
In order that we do not have to go to a system of charging our hygiene/cleaning patients for missed or broken appointments, we ask that you give a minimum of 24 hours notice if cancelling or rescheduling is absolutely necessary.	<ul> <li>Orthodontics</li> <li>Cosmetic Dentistry</li> </ul>	Whitening Implants	U Venee			
The contraction of the vertices of the and all the total of the observe of the volumenne	In order that we do not have we ask that you give a min	to go to a system of charging ou imum of 24 hours notice if ca	r hygiene/cleaning patients for mis ncelling or rescheduling is abso			

Signed by\_\_\_\_\_ Date\_\_\_\_\_