DAVID B. GREGORY D.D.S., P.A. — Registration & Medical History

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.

Today's Date ______________________________

ABOUT YOU

Name ______________________________ SS# ______________________ ☐ Female ☐ Male

Address ______________________________ Email Address: ______________________________

City ______________________________ State ______________ Zip ______________

Home Phone ______________________________ Business Phone ______________________________

Cell ______________________________ Birthdate ______/______/______ Age: __________

Marital status ☐ Single ☐ Married ☐ Widowed Name of Spouse ______________________________

Employer ______________________________ Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

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? ☐ Yes ☐ No If yes, please explain:____________

(For women) Are your currently pregnant? ☐ Yes ☐ No If yes, how many months?____________

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 ☐ Sulfa drugs ☐ Codeine/other narcotics
☐ Penicillin/other antibiotics ☐ Aspirin ☐ Latex sensitivity
☐ Iodine ☐ Other____________________

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

☐ Artificial Heart Valve
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Rheumatic Fever
☐ Hepatitis B or C
☐ AIDS/HIV Positive
☐ Artificial Joint________
☐ Snoring
☐ Dry Mouth
☐ Headaches
☐ TMJ/Jaw Pain
☐ Blood Disease
☐ Leukemia
☐ Blood Transfusion
☐ Excessive Bleeding
☐ Hemophilia
☐ Chest Pains
☐ Congenital Heart Disorder
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Pace Maker
☐ Heart Trouble/Disease
☐ Low Blood Pressure
☐ Stroke
☐ Hepatitis A
☐ Cold Sores/Fever Blisters
☐ Herpes
☐ Glaucoma
☐ Shingles
☐ Alzheimer's Disease
☐ Acid Reflux
☐ Ulcers
☐ Stomach/Intestinal Disease
☐ Fainting Spells/Dizziness
☐ Anaphylaxis
☐ Hay Fever
☐ Hives or Rash
☐ Asthma
☐ Breathing Problem
☐ Emphysema
☐ Frequent Cough
☐ Lung Disease
☐ Tuberculosis
☐ Sinus Trouble
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Cortisone Medicine
☐ Convulsions
☐ Epilepsy or Seizures
☐ Drug Addiction
☐ History of Tobacco Use
☐ Psychiatric Care
☐ Cancer________
☐ Chemotherapy
☐ Radiation Treatments
☐ Tumors or Growths
☐ Kidney Problems
☐ Liver Disease
☐ Renal Dialysis
☐ Diabetes - Type I or II
☐ Arthritis/Gout
☐ Bruise Easily

Have you had any serious illness not listed above? If yes, please explain____________________

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, 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 ☐ 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.**

The information I have given is true and accurate to the best of my knowledge.

Signed by____________________ ***Date***____________