John C. Griffiths, D.D.S., M.D.S.

Confidential **Patient** Information

Date _____

Patient's Name_____ Sex M / F
Last First Middle

Address _____
Street City State Zip

Primary Phone _____ Birthdate _____ Social Security # _____

Secondary Phone _____ E-Mail _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Confidential **Responsible Party** Information

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address_____ Primary Phone _____ Secondary Phone _____ E-Mail _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient_____

Employer _____ Occupation _____ No. years Employed _____

Spouse's Name _____
Last First Middle

Employer _____ Occupation _____ No. years Employed _____

Social Security # _____ Birthdate _____ Relationship to Patient_____

Insurance Information

Policy Holder's Name _____ Birthdate _____ Soc. Sec. #/ID # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? ❑ Yes ❑ No If yes:

Policy Holder's Name _____ Birthdate _____ Soc. Sec. #/ID # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Phone _____

Policy Holder's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

INFORMATION UPDATED: Date _____ Initial_____ INFORMATION UPDATED: Date _____ Initial_____
INFORMATION UPDATED: Date _____ Initial_____ INFORMATION UPDATED: Date _____ Initial_____

Emergency Information

Name of nearest relative not living with you _____

Phone _____ Relationship _____

MEDICAL HISTORY

GENERAL DENTIST _____ LAST CLEANING _____

IS PATIENT IN GOOD HEALTH? _____ ❑ YES ❑ NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS _____ ❑ YES ❑ NO

PLEASE LIST _____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

AIDS & HIV . . . . . ❑	Anemia . . . . . ❑	Prolonged Bleeding . . . ❑
Diabetes . . . . . ❑	Epilepsy . . . . . ❑	Fainting or Dizziness . . . ❑
Pneumonia . . . . . ❑	Asthma . . . . . ❑	Nervous Disorders . . . . ❑
Heart Trouble . . . . . ❑	Kidney Involvement . . . ❑	Hepatitis . . . . . ❑
Rheumatic Fever . . ❑	Tuberculosis . . . . . ❑	Endocrine Problems . . . ❑
Bone Disorders . . . ❑		

DOES PATIENT REQUIRE PRE-MEDICATION PRIOR TO DENTAL VISITS? ❑ YES ❑ NO

DOES PATIENT HAVE TENDENCY TO COLDS? ❑ SORE THROATS? ❑ EAR INFECTIONS ❑

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ ❑ YES ❑ NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS _____

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAS THE PATIENT REACHED PUBERTY? — GIRLS - HAS SHE STARTED MENSTRUATION? ❑ YES ❑ NO

BOYS - HAS HIS VOICE CHANGED? ❑ YES ❑ NO

HEIGHT _____ WEIGHT _____

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ ❑ YES ❑ NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ ❑ YES ❑ NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ ❑ YES ❑ NO

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? _____ ❑ YES ❑ NO

WHILE ASLEEP? _____ ❑ YES ❑ NO

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ ❑ YES ❑ NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ ❑ YES ❑ NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ ❑ YES ❑ NO

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

REASON FOR CONSULTATION _____

_____

INFORMATION UPDATED: Date _____ Initial_____ INFORMATION UPDATED: Date _____ Initial_____

INFORMATION UPDATED: Date _____ Initial_____ INFORMATION UPDATED: Date _____ Initial_____