PATIENT INFORMATION

Patient's Name ____ Male ☐ Female ☐
Last First Middle
I prefer to be addressed as _________________ E-Mail address _______________________
Address ____
Street Apt # City State Zip
Birthdate ___/___/___ Social Sec#______________ Driver Lic# __________ Marital Status ____
Home phone _______________ Work phone ______________ Cell phone ________________
Employer ______________________________ Occupation __________________________
Spouse's Name _____________________________ Cell phone ______________________
Spouse's Employer____________________________ Work phone_____________________
In case of emergency, other than your spouse, who may we contact?
Name _______________________ Relationship to patient ________ Phone ___________

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

Have dental insurance? Yes ☐ No ☐ If yes, please provide the office with your dental insurance card
Dental Insurance Co _______________________________ Phone ______________________
Name of insured ____________________________ Insured DOB ___________________
Insured Social Sec#____________________ Insured ID ________________ Group___________

DENTAL HISTORY

Reason for today's appointment ____
How long has it been since the last time your teeth were professionally cleaned? _______________
What condition do you feel your teeth are in now? Good ☐ Fair ☐ Poor ☐
Did you like your last dentist? Yes ☐ No ☐ Why? ________________________________
Have you had any complications during or following dental treatment? Yes ☐ No ☐
If yes, describe ____
____
Does food catch between your teeth? Yes ☐ No ☐
Are any of your teeth sensitive to hot, cold or pressure? Yes ☐ No ☐
Do you have Sinus headaches ___ Tension headaches ___ Migraines ___ Stiff or tight neck muscles ___
Do you grind your teeth or clench your jaw? Day - Yes ☐ No ☐ Night - Yes ☐ No ☐
Do you have pain/popping of the jaw joint? Day - Yes ☐ No ☐ Night - Yes ☐ No ☐
Do you have sore or tight jaw muscles? Yes ☐ No ☐
Do you wear mouth guards? Yes ☐ No ☐
Are you interested in cosmetically enhancing your smile? Yes ☐ No ☐
Do you experience dental anxiety? Yes ☐ No ☐
Do you want to know about sedation dentistry for patient comfort? Yes ☐ No ☐
Are you interested in hearing how a dental appliance can treat snoring? Yes ☐ No ☐
Do you have a significant gag reflex? Yes ☐ No ☐

HEALTH HISTORY

NOTE: A change in your health status should be reported to the office at the earliest possible time. To the best of my knowledge, the foregoing questions have been answered accurately.

Name of Medical Doctor ___________________________________ Phone ____________________________
Address ____
Date of last visit _____ / _____ / _____ Reason for visit ____

Currently under the care of a physician? Yes ☐ No ☐
If yes for what condition?___________________________
Are you taking any medication regularly? Yes ☐ No ☐
If yes, list medications and for what reason taken:
____
____
____
____
____
____

Do you have, or ever had an allergic reaction to:

Local Anesthetics	Yes ☐	No ☐
Penicillin	Yes ☐	No ☐
Sulfa Drugs	Yes ☐	No ☐
Aspirin	Yes ☐	No ☐
Codeine	Yes ☐	No ☐
Latex	Yes ☐	No ☐
Bandaid Only	Yes ☐	No ☐
Any severe food allergies?	Yes ☐	No ☐

Do you suffer from Dry-Mouth? Yes ☐ No ☐
Mild ☐ Moderate ☐ Severe ☐
Number of alcoholic drinks per week? ________________

In the last 6 months, have you taken one of the following Biophosphonate derivatives for the prevention of Osteoporosis? Yes ☐ No ☐
Circle if any: Fosamax, Actonel, Didronel, Boniva, Avedia, Skelid, Zometa, Prolia, ______________________________

Circle if any: heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular heartbeat

History of heart issues:

Valvulitis	Yes ☐	No ☐
Endocarditis	Yes ☐	No ☐
Artificial heart valve	Yes ☐	No ☐
Heart Valve Repair	Yes ☐	No ☐
Congenital Heart Conditions	Yes ☐	No ☐
Unrepaired Cyanotic CHD	Yes ☐	No ☐
Heart/Organ Transplants	Yes ☐	No ☐
Palliative Shunts & Conduits	Yes ☐	No ☐
Stroke	Yes ☐	No ☐

Circle if any: abnormal blood pressure, excessive bleeding or anemia
Blood thinners? If yes, name? ___________ Yes ☐ No ☐
Circle if taken daily: Fish Oil, Aspirin or Ibuprofen

Have you been told to take antibiotics prior to dental treatment? Reason: ____________________ Yes ☐ No ☐
Any prosthetic Joint replacement? Yes ☐ No ☐
Where and when was the surgery? __________________
____

Auto-immune disease? Yes ☐ No ☐
Name? ____
Rheumatoid arthritis? Yes ☐ No ☐
Circle if any: convulsions, fainting spells or epilepsy?
Circle if any: Parkinsons, dementia, other neurological disorders

Circle if any asthma, Tuberculosis or COPD
Mild ☐ Moderate ☐ Severe ☐
Tobacco use? Yes ☐ No ☐
If yes type & quantity: ______________________________

Circle if any Cancer, Tumors, Growths, Radiation Treatment or Chemotherapy. When ? __________________________
Are you currently being treated? Yes ☐ No ☐

Diabetic? Type? ______________________ Yes ☐ No ☐

Circle if any Hepatitis, jaundice, or liver disease, kidney problems or renal dialysis
Circle if any: HIV, AIDS, Syphillis
Do you suffer with GERD? (*Acid Reflux*) Yes ☐ No ☐

For women: Are you pregnant? Yes ☐ No ☐
Circle if you are taking any: hormones or birth control

Are there any other problems about your health of which you are aware? ___________________________________
____

____
Signature Date
If other than patient, indicate relationship:__________________

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Dale W. Greer, D.D.S.
5925 Forest Lane, Suite 311
Dallas, Texas 75230

HIPAA (Health Insurance Portability and Accountability Act)
Our Privacy Pledge

1. We want you to understand that we respect your privacy. We will not sell your health information or provide any of your health information to any outside marketing company. Dr. Greer or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider, if it is necessary for diagnosis, assessment, or treatment of your health/dental condition.

2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party (3rd party), such as an insurance carrier, your employer, a family member, other relative or close personal friend, adjustor or attorney who is involved in our care or to facilitate the payment related to your care.

3. Dr. Greer and staff may need to use your information (ex. name, address, phone number, e-mail and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. I authorize the use of my information to Dr. Greer and staff for communication purposes.

Please initial items below:

_____**AUTHORIZATION TO RELEASE RECORDS**: I voluntarily authorize the release of any information pertinent to my treatment to any (3rd party) insurance company, adjuster, health care provider, attorney, clinical and dental laboratories, pharmacies or referring dentists involved in my case.

_____**APPOINTMENTS**: When you schedule an appointment with our office, we reserve that time specifically for you. We require ***at least 24 hours cancellation notice***, as we have an extensive waiting list for appointments. If we do not receive 24 hours cancellation notice, this will be considered a “No Show” appointment. You will be billed a charge of $75.00 or greater for the time you reserved in our office.

_____**AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION**: I understand that Dr. Greer and staff may communicate with me electronically by email, text, and/or mobile phone number listed on my patient records. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing Dr. Greer's dental practice any updates to my email address and/or mobile phone number.

I can withdraw my consent to electronic communications at any time by calling the office of Dr. Dale W. Greer DDS at 972-233-4546 or emailing dr.dalegreer@yahoo.com.

_____**FINANCIAL RESPONSIBILITY**: I understand I am personally responsible for any treatment balance incurred for myself and/or my family with Dr. Dale Greer. ***We are pleased to assist you with your dental insurance; however Dr. Greer is not contracted with any insurance company.*** I understand I am responsible for any balance not paid, or covered by my insurance and if the insurance pays me personally, I am responsible for any balance due to Dr. Greer.

_____**PHOTO/IMAGES RELEASE**: I consent to allow use of any before and after photos or images taken of my treatment case to be used for educational purposes. *Please circle:* YES or NO.

I acknowledge I have reviewed and give my consent/approval to the above Practice Policies and Privacy Policy (HIPAA) for the office of Dr. Dale W. Greer and have received a copy if I requested.

Signature_________________________________**Date**____________

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