DALE GREER DDS

Date_____ Patient Name _____ Preferred name _____
First Last
Date of birth ____/____/____ Marital Status _____ Home# _____ Work# _____ Mobile# _____
Address _____
Street City State Zip
E-Mail _____ Preferred method of communication? Text☐ Email☐ Phone☐
Emergency contact other than your spouse: Name _____ Relationship to patient _____ Phone _____

DENTAL INSURANCE

Please provide the office with your dental insurance card.
Dental Insurance Co _____ Phone# _____ Insured Name _____ Insured DOB _____
Insured ID# _____ Insured SSN# _____ (for insurance purposes) Group# _____
Relationship to patient _____ Name of person responsible for account _____

HEALTH HISTORY

COMPLETE QUESTIONNAIRE AS ACCURATELY AS POSSIBLE!

LIST ALL MEDICATIONS TAKEN REGULARLY AND FOR WHAT REASON: _____
_____
_____
_____
_____
_____
_____
Physician name and phone#: _____
_____
Pharmacy name and phone#: _____
_____

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 ☐
Other allergies: _____
Number of alcoholic drinks per week? _____
Do you suffer from Dry-Mouth?.....Yes ☐ No ☐
Mild ☐ Moderate ☐ Severe ☐

History of heart issues?.....Yes ☐ No ☐
Endocarditis.....Yes ☐ No ☐
Artificial heart valve.....Yes ☐ No ☐
Heart Valve Repair.....Yes ☐ No ☐
Valvulitis.....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 ☐
Please describe other heart issues not listed: _____
_____

Abnormal blood pressure.....Yes ☐ No ☐.....High ☐ Low ☐
Excessive bleeding.....Yes ☐ No ☐
Anemia.....Yes ☐ No ☐

Blood thinners? If yes, name? _____ Yes ☐ No ☐
Check if taken daily: .....Fish Oil ☐ Aspirin ☐ Ibuprofen ☐

In the last 6 months, have you taken one of these Bisphosphonates or derivatives for the prevention of Osteoporosis? Yes ☐ No ☐
If yes, name? Fosamax ☐ Actonel ☐ Didronel ☐ Boniva ☐
Aredia ☐ Skelid ☐ Zometa ☐ Prolia ☐ Reclast ☐
Other:_____

Check if any:
Take antibiotics prior to dental treatment.....Yes ☐ No ☐
If yes, reason: _____
Joint replacement(s).....Yes ☐ No ☐
If yes, which joint replaced and date of the surgery?
_____
Auto-immune disease Name? _____ Yes ☐ No ☐

Neuropathy.....Yes ☐ No ☐
Diabetes Type? _____ Yes ☐ No ☐
Hepatitis.....Yes ☐ No ☐
Liver disease.....Yes ☐ No ☐
Renal disease.....Yes ☐ No ☐
HIV.....Yes ☐ No ☐
Cancer.....Yes ☐ No ☐
Radiation Treatment When? _____ Yes ☐ No ☐
Chemotherapy When? _____ Yes ☐ No ☐
Asthma.....Yes ☐ No ☐
Tuberculosis.....Yes ☐ No ☐
COPD.....Yes ☐ No ☐
GERD (*Acid Reflux*).....Yes ☐ No ☐
Tobacco.....Yes ☐ No ☐
Vape/E-cigarette.....Yes ☐ No ☐
Dip.....Yes ☐ No ☐
Please describe other health issues not listed:
_____
_____
_____
_____

For women:
Are you pregnant?.....Yes ☐ No ☐
Check if you are taking any:.....Hormones ☐ Birth control ☐

_____
Signature