DALE GREER DDS

COMPLETE THIS QUESTIONNAIRE AS ACCURATELY AS POSSIBLE!

Patient Name _____ Preferred name _____
First Last

Address _____
Street City State Zip

Date of birth ____/____/____ Marital Status _____ Home# _____ Work# _____ Mobile# _____

E-Mail _____ Preferred method of communication? Text☐ Email☐ Phone☐

Emergency contact other than 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

LIST ALL MEDICATIONS 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 ☐

Other: _____

Abnormal blood pressure.....Yes ☐ No ☐ If yes.....High ☐ Low ☐

Excessive bleeding.....Yes ☐ No ☐

Anemia.....Yes ☐ No ☐

Blood thinners?.....Yes ☐ No ☐

If yes, name? _____

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:_____

Take antibiotics prior to dental treatment?.....Yes ☐ No ☐

If yes, reason: _____

Joint replacement(s)? .....Yes ☐ No ☐

If, yes, which one? _____

Date of the surgery? _____

Name of surgeon? _____

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 ☐

For women:

Are you pregnant?.....Yes ☐ No ☐

Check if you are taking any:.....Hormones ☐ Birth control ☐

Please describe other health issues not listed:

_____

_____

_____

_____

Signature **Date**

RevOCT2026

DALE W. GREER, D.D.S.

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 $65.00 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.

My most preferred method of electronic communication:
_____ Text Mobile number: _____
_____ Email Email address: _____

_____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.

_____HEALTH AND ACCOUNT AUTHORIZATION: I authorize the release of dental health and account information to the following people:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____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.

Patient name _____ Date _____
Signature _____