DALE GREER DDS
PATIENT INFORMATION

Patient Name _____Male ☐ Female ☐
First Middle Last
Preferred name _____ Marital Status _____ Date of birth _____/_____/_____ SSN# _____
Address _____
Street City State Zip
Home# _____ Work# _____ Mobile# _____
E-Mail _____
Preferred method of communication? Text ☐ Email ☐ Phone ☐
Occupation _____ Employer Name _____
Spouse's Name _____ Cell# _____
Spouse's Employer Name _____ Work# _____
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? _____

DENTAL INSURANCE

Have dental insurance? Yes ☐ No ☐ If yes, please provide the office with your dental insurance card.
Dental Insurance Co _____ Phone# _____ Group# _____
Insured Name _____ Insured DOB _____
Insured ID# _____ Insured SSN# _____ (for insurance purposes)
Relationship to patient _____ Person responsible for account _____

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 ☐ If yes, what area? _____
Do you have any of the following? Sinus headaches☐ Tension headaches☐ Migraines☐ Stiff or tight neck muscles☐
Do you grind your teeth or clench your jaw? Yes ☐ No ☐ If yes, daytime? Yes ☐ No ☐ Nighttime? Yes ☐ No ☐
Do you have pain/popping of the jaw joint? Yes ☐ No ☐ If yes, daytime? Yes ☐ No ☐ Nighttime? 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

PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS ACCURATELY AS YOU CAN. IT IS YOUR RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

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:_____

Endocarditis Yes □ No □
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