DALE GREER DDS
PATIENT INFORMATION

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

Employer Name _____ Occupation _____
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 COMPLETE THIS QUESTIONAIRE 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