A. Scott Grivas III, DDS, INC.
www.asmiledesign.com

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____ PATIENT NUMBER

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

FORM 065936 N/12/04 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

REGISTRATION

A. Scott Grivas III, DDS, INC.
www.sacsmiledesign.com

NAME	DATE OF BIRTH	CHART #

Health History Questionaire (confidential)

Date: _____

1. Have you had any health problems in the past five (5) years? ☐ Yes ☐ No
2. Have you seen a physician or other health care provider in the past two (2) years? ☐ Yes ☐ No
   Physician's name: _____ Phone # or City: _____
3. Is there any activity your doctor says you cannot do? ☐ Yes ☐ No
4. Have you been hospitalized or had a serious illness in the past five (5) years? ☐ Yes ☐ No
5. Have you ever had a bleeding problem? ☐ Yes ☐ No

Baseline Vital Signs	Temp	Pulse	Resp	B.P.			
				Date			

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

Heart/Blood Vessels

Rheumatic fever ... Yes No
Rheumatic heart disease ... Yes No
Heart valve damage ... Yes No
Heart murmur ... Yes No
Congenital heart defect ... Yes No
Artificial heart valve ... Yes No
Prolapsed heart valve ... Yes No
High blood pressure ... Yes No
Heart attack (Date ____) ... Yes No
TIA/stroke (Date ____) ... Yes No
Heart Surgery (Date ____) ... Yes No
Vascular Surgery (Date ____) ... Yes No
Pacemaker ... Yes No
Coronary heart failure ... Yes No
Congestive heart failure ... Yes No
Angina pectoris/chest pain ... Yes No
Irregular/rapid heart beats ... Yes No
Other heart or vessel disorder ... Yes No

Blood

Blood clots or thrombosis ... Yes No
Anemia ... Yes No
Sickle cell disease / trait ... Yes No
Hemophilia ... Yes No
Transfusion (Date ____) ... Yes No
Bruise easily for no apparent reason ... Yes No
Other blood disorder ... Yes No

Nervous System

Epilepsy ... Yes No
Seizure disorder ... Yes No
Multiple sclerosis ... Yes No
Trigeminal neuralgia ... Yes No
Chronic pain ... Yes No
Anxiety/depression ... Yes No
Alzheimer's disease/dementia ... Yes No
Psychiatric treatment ... Yes No
Psychological counseling ... Yes No
Persistent dizziness/fainting spells ... Yes No
Persistent numbness/tingling ... Yes No
Other nervous system/mental disorder ... Yes No

Head and Neck

Glaucoma ... Yes No
Chronic sinusitis ... Yes No
Injury to head, neck, jaw or teeth ... Yes No
Headaches ... Yes No
Unexplained visual change ... Yes No
Frequent or severe nosebleeds ... Yes No
Persistent sore throat or hoarseness ... Yes No
Recurrent neckache or neck pain ... Yes No
Recent difficulty swallowing ... Yes No
Other head or neck disorder ... Yes No

Endocrine

Diabetes ... Yes No
Low thyroid ... Yes No
Other thyroid condition ... Yes No
Cushings syndrome ... Yes No
Parathyroid condition ... Yes No
Other endocrine condition ... Yes No

Musculoskeletal / Connective Tissue

Sjögren's syndrome ... Yes No
Arthritis ... Yes No
Artificial joint (Date ____) ... Yes No
Fibromyalgia/rheumatism ... Yes No
Chronic back pain ... Yes No
Other muscle or bone disorder ... Yes No

Respiratory

Tuberculosis (TB) ... Yes No
Asthma ... Yes No
Chronic bronchitis ... Yes No
Emphysema ... Yes No
Persistent cough ... Yes No
Cough up bloody sputum ... Yes No
Shortness of breath ... Yes No
Other respiratory disorder ... Yes No

Urinary Tract

Kidney disease ... Yes No
Renal dialysis ... Yes No
Venereal disease ... Yes No
Sexually transmitted disease ... Yes No
Other urinary disorder ... Yes No

Digestive System

Hepatitis ... Yes No
Cirrhosis of the liver/liver disease ... Yes No
Ulcers ... Yes No
Jaundice ... Yes No
Frequent heartburn or reflux ... Yes No
Frequent nausea/vomiting ... Yes No
Other digestive disorder ... Yes No

Cancer History

Cancer ... Yes No
If yes, what type _____
Leukemia ... Yes No
Benign tumors/growths ... Yes No
Type of treatment:
Surgery ... Yes No
Radiation therapy ... Yes No
Chemotherapy ... Yes No
Hormone therapy ... Yes No

Allergy History

Are you allergic to or have you ever had a bad reaction to any of the following?
Dental anesthetics ... Yes No
Penicillin ... Yes No
Sulfa drugs ... Yes No
Other antibiotics ... Yes No
Aspirin ... Yes No
Latex products ... Yes No
Metals, including jewelry ... Yes No
Other allergy ... Yes No

Family History

Has anyone in your family (grandparent, parent, sibling, child) ever had:
Diabetes ... Yes No
Heart disease ... Yes No
Depression or anxiety ... Yes No
Tuberculosis ... Yes No
Any disorder that "runs in" your family ... Yes No

Please continue on other side ✏

A. Scott Grivas III, DDS, INC.
www.aacsmiledesign.com

NAME	DATE OF BIRTH	CHART #

HEALTH HISTORY QUESTIONAIRE (continued)

Date: _____

Please circle "yes" if you have ever had the following. If you are not sure, do not answer the question.

MISCELLANEOUS

Lupus erythematosus ..... Yes No
Organ transplant ..... Yes No
If yes, which organ? _____
Suppressed immune system ..... Yes No
Persistent fever ..... Yes No
Taken steroid/prednisone ..... Yes No
Tested positive for HIV ..... Yes No
Been diagnosed with AIDS..... Yes No
Taken prescription diet pills ..... Yes No
If yes, please check type:
☐ Pondimin ☐ Phen-fen
☐ Redux ☐ Other _____

MISCELLANEOUS (CONTINUED)

Used tobacco products..... Yes No
If yes, what type? _____
How much? _____ How long? _____
Still using tobacco?..... Yes No
Would you like to quit?..... Yes No
Quit on? (Date ____)
Drink alcoholic beverages ..... Yes No
If yes, how much? _____
Used methamphetamine, amphetamines or "speed" .... Yes No
Used intravenous drugs ..... Yes No
Used cocaine or "crack" ..... Yes No

MISCELLANEOUS (CONTINUED)

Used any other recreational drug. Yes No
Are you a recovering alcoholic or addict? ..... Yes No

WOMEN ONLY

Are you pregnant or is there a possibility that you may be pregnant? ..... Yes No
If yes, due date _____
Are you breast feeding? ..... Yes No
Are you in or have you passed through menopause (change of life)?. Yes No

Do you have any other condition that you think we should know about? ☐ Yes ☐ No _____

Please circle all the medications you are currently taking:

Heart	Blood thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood pressure	Insulin/diabetic drugs	Antihistamine	Antidepressants
Digitalis	Oral contraceptive	Thyroid	Cyclosporine A	Pain
Aspirin (____ tabs/day)	Steroids/Cortisone	Nifedipine		

List medication names and dosages (include over-the-counter, herbal and nutritional supplements):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Signature of Patient, Parent or Guardian Date	Signature and # of Reviewing Staff Date

HEALTH UPDATES *[Required at least every six (6) months; more often as indicated]*

Date	Note changes below	Patient Signature	Staff Review	
	INITIAL REVIEW BY DENTIST			

Note: A new Health History Questionnaire should be completed at least every two (2) years; more often if indicated or if all Health Update spaces above have been used.