



# AVALON DENTISTRY

FAMILY & COSMETIC

James D. Grant D.M.D.

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help!

Patient Number: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Date: \_\_\_\_\_

## Patient Information (Confidential)

Name (Full): \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
If Student, Name of School/College: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  F/T  P/T  
Patient's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Drivers License #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Financial Institution: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_  
Is this person currently a patient in our office?  Yes  No

## Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Date Employed: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Union or Local #: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max Annual Benefit: \_\_\_\_\_

### DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ Date Employed: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Union or Local #: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max Annual Benefit: \_\_\_\_\_

Over Please

# Patient Medical History

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? . . . . . (if yes, please explain) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? . . . . . (If yes, what medication(s) are you taking? _____)              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Phen-Fen/Redux? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 8. Are you allergic to or have you had any reactions to the following: |                          |                          |
| Local Anesthetics (i.e. Novocain) . . . . .                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Metals (i.e. nickel, mercury, etc.) . . . . .                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list) _____  | <input type="checkbox"/> | <input type="checkbox"/> |

7. Do you have or have you had any of the following?

- |                                  | Yes                      | No                       |  | Yes                      | No                       |                                 | Yes                      | No                       |
|----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| High Blood Pressure . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease . . . . .                | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains . . . . .           | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack . . . . .           | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker . . . . .            | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever . . . . .        | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur . . . . .                 | <input type="checkbox"/> | <input type="checkbox"/> | Stroke . . . . .                | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> | Angina . . . . .                       | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis . . . . .          | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma . . . . .                 | <input type="checkbox"/> | <input type="checkbox"/> | Anemia . . . . .                       | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy . . . . .     | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure . . . . .     | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema . . . . .                    | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma . . . . .              | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | Cancer . . . . .                       | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia . . . . .               | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis . . . . .                    | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes . . . . .               | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement / Implant . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases . . . . .        | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infections . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem . . . . .        | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                     | <input type="checkbox"/> | <input type="checkbox"/> |

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? . . . . .     | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquid/foods? . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? . . . . .      | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? . . . . .                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? . . . . .               | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? |                          |                          | 14. Do you wear dentures or partials? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement _____   |                          |                          |
| Pain (joint, ear, side of face) . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Patient (or Parent if Minor) \_\_\_\_\_

# Agreement for Extension of Credit

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 90 days from the first billing to pay 5% per month on the unpaid balance (annual rate of 60%) with a minimum charge of \$10.00 per month.

I/We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Date \_\_\_\_\_ Signature \_\_\_\_\_