grauer ORTHODONTICS

PATIENT INFORMATION & PRACTICE AGREEMENT

WELCOME
To assist us in providing the most complete service, please provide the following information and health history

TELL US ABOUT YOU

___ Dr. ____Mr. ____Mrs. ___ Ms.

Full Name: ______________________

I prefer to be called: ______________________

Who referred you to us ______________________

Birthdate: ____/____/____ ____ Male ____ Female

Social Security Number: ______________________

Address: ______________________

____

E-mail Address: ______________________

Home Number:(______) ______________________

Cell/Other:(______) ______________________

Where and when is the best way to reach you?

____

Occupation:______________________

Employer: ______________________

Employer's Address: ______________________

Work Number: (_____) ______________ Ext. ______

Name of Spouse:

____

In the event of an emergency, who should we contact?

Name: ______________________

Relation to you: ______________________

Work Number:(______) ______________________

Home Number:(______) ______________________

Cell Number: (______) ______________________

DENTAL INFORMATION

Please provide information on the last dentist you have seen:

Name: ______________________

Phone Number: (______) ______________________

Date Range Seen: ______________________

Type of Treatment: ______________________

What is the primary reason you came to our office today?

____

____

____

Are you currently experiencing pain/discomfort? ☐ Yes ☐ No

Current dental health: ☐ Good ☐ Fair ☐ Poor

Does food catch between your teeth? ☐ Yes ☐ No

Are your teeth sensitive to cold or sweets? ☐ Yes ☐ No

Any unpleasant experiences in a dental office? ☐ Yes ☐ No

If yes, please explain: ______________________

____

Y	N	
__	__	Do you have dental insurance?
__	__	Are your teeth somewhat yellowed, darkened, or stained?
__	__	Have you ever experienced pain or discomfort in your jaw joint? (TMJ / TMD)
__	__	Are there spaces between any of your teeth?
__	__	Do you grind your teeth or are any of the biting edges on your teeth chipped or worn down?
__	__	Do you have a "gummy" smile —showing too much gum tissue or have gums that are too thick?
__	__	Are your gums red, puffy, or do they bleed?
__	__	Do you smoke?
		If Yes, How much? ______________
__	__	Do you drink alcohol?
		If Yes, How much? ______________

MEDICAL HISTORY

Do you consider your current overall physical health:
_____Good _____Fair _____Poor
Are you currently under the active care of a physician or do you have any present health issues?
_____Yes _____No
Please Explain: ______________________________
Do you need to be premedicated with antibiotics for any heart or other conditions before dental treatment?
_____Yes _____No
Are you taking any prescription over-the-counter-medications? (including ibuprofen, diet supplements, etc.)
_____Yes _____No
Please list each one: ______________________________

Are you pregnant or nursing? _____Yes _____No
If yes, which trimester? _____1st _____2nd _____3rd

Have you ever had any of the following illnesses or medical problems in the past five years?

Y	N		Y	N	
__	__	Abnormal Bleeding	__	__	Herpes/Fever Blisters
__	__	Alcohol/Drug Abuse	__	__	High Blood Pressure
__	__	Allergies	__	__	HIV + /AIDS
__	__	Anemia	__	__	Hospitalization for Any Reason
__	__	Arthritis	__	__	Jaw Pain/TMJ
__	__	Artificial Bones/Joints/ Valves	__	__	Kidney Problems
__	__	Asthma	__	__	Liver Disease
__	__	Blood Transfusion	__	__	Low Back/Hip/Leg Pain
__	__	Bone / Joint Disease	__	__	Low Blood Pressure
__	__	Cancer/Chemotherapy	__	__	Lupus
__	__	Colitis	__	__	Mitral Valve Prolapse
__	__	Congenital Heart Defect	__	__	Neck/Shoulders/Arm Pain
__	__	Diabetes	__	__	Pacemaker
__	__	Difficulty Breathing	__	__	Psychiatric Care
__	__	Eating Disorders	__	__	Radiation Treatment
__	__	Emphysema	__	__	Hepatitis
__	__	Epilepsy	__	__	Rashes
__	__	Fainting Spells	__	__	Rheumatic /Scarlet Fever
__	__	Frequent Headaches	__	__	Seizures
__	__	Gingivitis or	__	__	Sexually Transmitted
__	__	Periodontal Disease	__	__	Disease
__	__	Glaucoma	__	__	Shingles
__	__	Hay fever	__	__	Sickle Cell Disease
__	__	Headaches	__	__	Spasms/Cramps
__	__	Heart Attack	__	__	Sprains/Broken Bones
__	__	Heart Murmur	__	__	Thyroid Problems
__	__	Heart Surgery	__	__	Tuberculosis (TB)
__	__	Hemophilia	__	__	Ulcers
__	__	Mental Health Problem, If yes please explain			

____

Please list any significant medical condition(s) or surgeries that you have had (not listed above): ______________________________

ALLERGIES

Are you allergic to any of the following?

Y	N		Y	N	
__	__	Aspirin	__	__	Latex
__	__	Codeine	__	__	Penicillin
__	__	Dental Anesthetics	__	__	Tetracycline
__	__	Erythromycin	__	__	Any Metals
__	__	Sulfites	__	__	Other

Please list any other drugs or items that you are allergic to:
____
____

YOUR CONSENT

The information I have provided on this form is accurate and complete to the best of my knowledge, information, and belief. I will notify the Practice at the soonest practical moment of any changes in the information I have provided. In consideration of being accepted as a patient of the Practice, I agree to abide by the terms and conditions of this Patient Application & Practice Agreement.

By signing below, I acknowledge that I have been given time to read and have completely read (or had read to me) the preceding information in this document and I acknowledge that the Practice has explained to me in general terms the description of certain anticipated dental procedures and treatments, alternatives (including non-treatment), and the risks and inconveniences of treatments. By proceeding with each and every step in my treatment, I acknowledge: (1) I have been given the opportunity to ask any questions and any questions have been answered or explained to my satisfaction prior to performance of any treatment or procedure, and (2) I authorize the Practice to perform any and all such recommended forms of treatment, medication and therapy that may be necessary or advised. I understand that during the course of the procedures described above, it may be necessary, appropriate, or the Practice's recommendation to perform additional procedures which are unforeseen or not known to be necessary, appropriate, or recommended at the time this consent is given. I consent to and authorize the performance of such additional procedures as they deem necessary, appropriate, or recommended under the circumstances.

Signature:______________________ Date: ______________

Patient's Authorized Representative
(If patient is under 18 years of age or you are consenting to the care of another)
I have the legal authority to sign this consent on behalf of:
Patient Name:______________________
Your Relationship to Patient: ______________________
Signature: ______________________ Date: ______________

AUTHORIZATION

I authorize the release of medical and dental information to insurance carriers and to other health care providers involved in my care and the use of records by Dr. Grauer for teaching purposes and scientific publication. In the future, please advise Dr.
Grauer of any changes in your medical or dental health while under the care of our office.

______________________ ______________
Signature Date