JOSEPH P. GRASKEMPER, D.D.S.

The Bellport Village Dentist

REGISTRATION & HEALTH HISTORY FORM

TODAY'S DATE:

Patient Information: (Please print)

Please complete this entire questionnaire. This information is necessary for your protection and will be considered confidential.

LAST NAME (Dr., Mr., Mrs., Miss, Ms.)	FIRST	MIDDLE INITIAL	PREFERRED NAME	SEX	AGE

STREET ADDRESS	CITY	STATE	ZIP	PHONE #
				( )

BIRTHDATE (Month Day Year)	SOCIAL SECURITY #	REFERRED BY	CELL #
			( )

EMPLOYED AT	STREET	CITY	ZIP	# YEARS	PHONE #
					( )

OCCUPATION	MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S EMPLOYER

PREFERRED E-MAIL	SCHOOL NAME IF FULL-TIME STUDENT	CITY	STATE

PARENT OR GUARDIAN'S LAST NAME	FATHER'S NAME	MOTHER'S NAME

PREVIOUS DENTIST	CITY	CURRENT PHYSICIAN	CITY	PHONE #
				( )

PERSON TO CONTACT IN CASE OF EMERGENCY	RELATIONSHIP

STREET ADDRESS	CITY	STATE	ZIP	PHONE #
				( )

Person Responsible for Account: (If different from patient)

LAST NAME (Dr., Mr., Mrs., Miss, Ms.)	FIRST	MIDDLE INITIAL	SOCIAL SECURITY #	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP	PHONE #
				( )

EMPLOYED AT	STREET	CITY	ZIP	PHONE #
				( )

Dental

	Yes	No
Is your general health good	☐	☐
When was your last visit to a dentist		
What was done		
Have you had regular check-ups	☐	☐
How often do you brush		
Do you use floss, stimulators or water jet	☐	☐
Teeth sensitive to cold, hot, sweet or pressure	☐	☐
Bleeding gums, bad taste, mouth odor	☐	☐
Problems chewing, swallowing or breathing	☐	☐
Growths or sore spots in mouth	☐	☐
Jaw, neck or ear pain	☐	☐
Aware of loose, broken or missing restorations	☐	☐
Food trap areas	☐	☐
Concerned about appearance of teeth (whiter?)	☐	☐
Periodontal therapy (treatment of gums)	☐	☐
Smoke	☐	☐
Orthodontics (braces), Date		
Explain any other dental concern		

I hereby acknowledge the medical history is correct and complete and will inform of any future changes.

X_____

If the Patient is a Child

Is this is the child's first dental visit	☐	☐
Habit of thumb-sucking or tongue-thrusting	☐	☐

Medical

	Yes	No
Date of last physical exam		
Any change in your health in past year	☐	☐
Now under the care of a physician	☐	☐
Any serious illness or operation	☐	☐
Artificial joints	☐	☐
Rheumatic Fever or Rheumatic Heart Disease	☐	☐
Cardiovascular (heart attack, heart murmur, Mitro Valve Prolapse,	☐	☐
high or low blood pressure, stroke, pacemaker	☐	☐
Sinus trouble, hay fever, asthma, emphysema	☐	☐
Fainting spells or seizures	☐	☐
Diabetes, bowel or urinary condition	☐	☐
Hepatitis, jaundice or tuberculosis	☐	☐
Indigestion, nausea, vomiting or ulcers	☐	☐
Kidney or bladder problems	☐	☐
Excessive bleeding, blood disorders, anemia, transfusions, taken Fen-Phen..	☐	☐
AIDS, HIV	☐	☐
Surgery or x-ray treatment for tumor or growth	☐	☐
Taking daily aspirin, blood thinners	☐	☐
Taking Bisphosphonates for bone density (Fosomax, Boniva)	☐	☐
Medications and/or over the counter drugs, vitamins and /or suppliments	☐	☐

Allergies or adverse reactions to:

Local anesthetics (novocaine, lidocaine, etc.)	☐	☐
Penicillin or other antibiotics	☐	☐
Codeine or other narcotics	☐	☐
Latex, foods,chemicals, any other allergies	☐	☐
Unfavorable reaction to prior medical or dental care	☐	☐
Vision, hearing, tasting or speech difficulties	☐	☐
Headaches (how often/when)	☐	☐
Jewelry Sensitivity	☐	☐
Women (Are you now pregnant)	☐	☐
Women (Are you taking oral contraceptives)	☐	☐
Anything about your health the doctor should know	☐	☐

All Patients: Please read, sign and date.

The undersigned hereby authorize doctor to perform any and all forms of treatment, medication and therapy, (with patients prior consent)

that may be indicated in connection with (Name of Patient) _____ and further authorizes and consents that Doctor choose and emply such assistance as he deems fit. I also understand dental treatment and the use of anesthetic agents embodies a certain risk including needle separation. I understand that necessary changes may occur during the course of treatment, of which I will be informed. I acknowledge that I have received no guarantees or assurances about the outcome of the treatment or any component(s), benefits or results. I understand that if treatment modifications are required as treatment progresses, the fee(s) may also need to be modified to reflect those changes, of which I will be notified when it becomes apparent. If you have any questions or concerns please ask. Any balance over 90 days will be charged 9% monthly service charge or a minimum of $1.00 Any costs of collection will be added to balance due. I understand that a fee may be charged if I do not show for an appointment.

Signature: _____ Date: _____

Relationship: _____

Dental Insurance Patients: Please read, sign and date.

I agree to have my signature considered to be "on File" for the purposes of insurance form processing, and to be responsible for payment for any service or portion of service not covered by insurance. In the event of default in payment, patient or party responsible for fees agrees to pay any and all costs of suit, collection and attorney's fees.

I authorize release of necessary information relating to the processing of dental insurance forms. In order for us to process your insurance forms more rapidly and to assist you in getting all the benefits to which you are entitled, please sign and date below.

Signature: _____ Date: _____
("on file")

Dental Insurance Information:

	PRIMARY CARRIER	*SECONDARY CARRIER*
NAME (Last, First, M.I.)		
STREET, PHONE	( )	( )
CITY, STATE, ZIP		
BIRTHDATE (M/D/Y)		
SOCIAL SECURITY #		
Employer		
STREET, PHONE	( )	( )
CITY, STATE, ZIP		
Insurance Company		
STREET, PHONE	( )	( )
CITY, STATE, ZIP		
GROUP #		