Graystone Family Dental
3421 Graystone Pl SE
Conover, NC 28613
(828)328-3418

Date_____

Name_____ Sex ____M____F Age_____ Date of Birth_____
(Last) (First) (MI)

Address_____
(Mailing Address)

City_____State_____ Zip_____Cell Phone: _____

Marital Status: Married_____ Widowed_____ Single_____ Minor_____ Separated_____ Divorced_____ Partnered____

**SSN: _____ EMAIL: _____**

Patient Employer/School: _____ Work Phone: _____

## Emergency Contact

Name _____ Relationship to Patient? _____
LAST FIRST MI

Home Phone: _____ Cell Phone: _____ Work Phone: _____

## Primary Insurance

Who is responsible for this account: _____Relationship to Patient? _____

Home Phone_____ Cell Phone_____

Insurance Co. _____ Group#_____

**Subscriber's Name: _____ Birth Date: _____**

**SSN: _____** Employer: _____

***If the patient has additional insurance please notify someone at the front desk***
****WHEN FILING INSURANCE THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICY HOLDER ARE REQUIRED****


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## Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to GRAYSTONE FAMILY DENTAL all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I certify that all of this information is true and accurate including the following medical information.

Signature/Relationship: _____ Date: _____

**PATIENT NAME:** _____ **DOB:** _____

## Dental History

Reason for today's visit: _____

Former Dentist_____City/State_____

Date of last dental visit: _____ Date of last dental x-rays: _____

## Health History

Physician's Name _____ Date of Last Visit: _____

Name of Physician's Practice: _____Phone Number: _____

**Are you on a Pain Contract?____Yes____No If so, with which Doctor?**
**_____**

Do you use tobacco products? ___Yes ___No

**WOMEN ONLY:**
Are you pregnant? ___Yes ___NO Due Date _____/_____/_____
MONTH DAY YEAR

Are you nursing? ___Yes ___No Are you taking Birth Control? ___Yes ___No

_____
__

Do you have a history of bacterial endocarditis? ____Yes ____No *If yes, when were you diagnosed? _____

Do you have history of any type of cancer? _____Yes _____No *If yes, what type of Cancer? _____

Are you currently taking chemotherapy or radiation treatments? _____Yes _____No

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Have you ever taken any of the group of drugs collectively referred to as "**bisphosphanates**"? These include but are not limited to: Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No

Have you or are you currently taking any blood thinners? ____Yes ____No *If yes, what medication? _____

Do you have any stents, valves, or joint replacements? _____Yes ____No *If yes, when? _____

Do you have history of any heart attacks or strokes? ____Yes ____No *If yes, when? _____

**PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**PLEASE LIST ANY KNOWN ALLERGIES:**

_____ _____ _____

_____ _____ _____

**PATIENT NAME:** _____ **DOB:** _____

**Pharmacy Name:** _____ Phone: _____

Address _____City_____State_____ZIP_____

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**Place a mark (X) on "Yes" or "No" to indicate if you have or have had any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | ___Yes ___No | Epilepsy | ___Yes ___No | Rheumatic Fever | ___Yes___No |
| Anemia | ___Yes ___No | Fainting/Dizziness | ___Yes ___No | Scarlet Fever | ___Yes ___No |
| Arthritis, Rheumatism | ___Yes ___No | Glaucoma | ___Yes ___No | Short of Breath | ___Yes ___No |
| Artificial Heart Valve | ___Yes ___No | Headaches | ___Yes ___No | Sinus trouble | ___Yes ___No |
| Artificial Joints | ___Yes ___No | Heart Murmur | ___Yes ___No | Skin Rash | ___Yes ___No |
| Asthma | ___Yes ___No | Heart Problems | ___Yes ___No | Special Diet | ___Yes ___No |
| Bleeding abnormally, with | | Hepatitis Type___ | ___Yes ___No | Stroke | ___Yes ___No |
| Extractions or surgery | ___Yes ___No | Herpes | ___Yes ___No | Swollen Limbs | ___Yes ___No |
| Blood Disease | ___Yes ___No | High Blood Pressure | ___Yes ___No | Swollen Glands | ___Yes ___No |
| Cancer | ___Yes ___No | Jaundice | ___Yes ___No | Thyroid Problem | ___Yes ___No |
| Chemical dependency | ___Yes ___No | Kidney Disease | ___Yes ___No | Tuberculosis | ___Yes ___No |
| Chemotherapy | ___Yes ___No | Liver Disease | ___Yes ___No | Tumor or growth on head | |
| Circulatory Problems | ___Yes ___No | Low Blood Pressure | ___Yes ___No | or Neck | ___Yes ___No |
| Congenital Hlth Lesions | ___Yes ___No | Mitral Valve Prolapse | ___Yes ___No | Ulcer | ___Yes ___No |
| Cortisone Treatments | ___Yes ___No | Nervous Problems | ___Yes ___No | Weight Loss | ___Yes ___No |
| Cough, persistent | ___Yes ___No | Pacemaker | ___Yes ___No | OTHER: _____ | |
| Diabetes | ___Yes ___No | Psychiatric Care | ___Yes ___No | _____ | |
| Emphysema | ___Yes ___No | Radiation Treatment | ___Yes ___No | _____ | |

**Additional Notes:**

_____

_____

_____

_____

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_____

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