Justin G. Frandsen DDS • Brandon S. Griffin DMD

Family & Cosmetic Dentistry

PATIENT INFORMATION

Name (First, Last, MI) _____ Preferred Name_____

Today's Date _____ Preferred Contact Method: ☐Phone ☐Email ☐Text Gender: Male Female

Birth date___/___/_____Age _____ Social Security #_____-____-_____ Email Address_____

Current Address _____City_____ State_____Zip_____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Driver's License # _____ Employer _____ Years at Employer_____

Employer's Address _____ City: _____ State:_____ Zip:_____

Whom may we thank for referring you to our office? _____

Marital Status: Single Married Separated Divorced Widowed

EMERGENCY CONTACT INFORMATION-(Other than Spouse/Partner)

Name of Contact _____ Relationship _____

Contact Home Phone (____)_____ Contact Work or Cell Phone (____)_____

Contact Address _____ City:_____ State:_____ Zip:_____

Responsible Party for Account (if other than yourself)

Name _____ Relationship _____

Home Phone (____)_____ Work Phone (____)_____

Billing Address _____ City_____ State_____ Zip_____

Driver's License #_____ Employer _____ Years at Employer_____

Employer's Address_____ City_____ State_____ Zip_____

If patient is a minor please provide: Mother's Date of Birth_____ Father's Date of Birth_____

SPOUSE INFORMATION

Name_____ Birth date_____ Social Security #_____-_____-_____

Cell Phone (____)_____ Work Phone (____)_____ Employer_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Policy Holder's Name_____
Policy Holder's DOB_____SSN#_____
Policy Holder's Employer_____
Insurance Company_____
Insurance Company's Address_____
Insurance Company's Phone #_____
Group #_____ ID #_____
Does your insurer provide dental coverage? _____

SECONDARY INSURANCE CARRIER
(ONLY IF YOU HAVE DOUBLE COVERAGE)

Policy Holder's Name_____
Policy Holder's DOB_____
Policy Holder's Employer_____
Insurance Company_____
Insurance Company's Address_____
Insurance Company's Phone #_____
Group #_____ ID #_____
Does your insurer provide dental coverage?_____

DENTAL HISTORY

1. Do you have a specific Dental problem? Y N
   Describe:_____
2. Do you have dental examinations on a routine basis? Y N
   Date of Last Visit:_____
   Date of last dental x-rays:_____
3. Do you think you have active decay or gum disease? Y N
4. Do you brush and floss on a routine basis? Y N
   Describe:_____
5. Do you gums bleed? Y N
   Describe:_____
6. Have you ever been treated for perio/gum disease? Y N
7. Any loose teeth? Y N
8. Does food catch between your teeth? Y N
9. Do you have problems with bad breath? Y N
10. Do you have clicking, popping, or discomfort in the jaw joint? Y N
11. Do you brux or grind? Y N
12. Do you wear dentures? Y N
13. Would you be interested in anchoring your dentures or permanent replacements? Y N
14. Are you interested in whitening your teeth? Y N
15. Would you like your smile to look better or different?
    Describe:_____
16. Is there anything we can do to make your visit a more positive experience?_____
    _____
    _____
17. Name of previous Dentist:_____

I AUTHORIZE THE TAKING OF ANY NEEDED X-RAYS, PICTURES, OR STUDY MODELS_____
Signature Date

MEDICAL HISTORY

Are you under a physician's care now? Y N If so, why?:
_____
Physician's name:_____
Please list any medications you are currently taking:_____
_____
_____
Have you ever been hospitalized or had a major operation?
_____
_____
Have you ever had a serious head or neck injury? Y N
If yes:_____
Do you take, or have you taken, Phen-Fen or Redux? Y N
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y N

Are you on a special diet? Y N
Do you take blood thinners? Y N
Do you use tobacco? Y N
Do you use controlled substances? Y N
If yes:_____
Do you have any allergies or adverse reactions to any of the following: (please check box)

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Metal
☐ Local Anesthetic ☐ Nitrous Oxide ☐ Percodan Other:_____
☐ Penicillin ☐ Valium ☐ Acrylic _____
☐ Latex ☐ Sulfa Drugs ☐ Fluoride _____

WOMEN

Please check if any of the following apply to you:
☐ Pregnant/trying ☐ Nursing ☐ Taking contraceptives

Please circle if you have, or have had, any of the following:

Aids/HIV Positive	Cold Sores/Fever Blisters	Hay Fever/Seasonal Allergies	Leukemia	Shingles
Alzheimer's Disease	Congenital Heart Disorder	Heart Attack/Failure	Liver Disease	Sickle Cell Disease
Anaphylaxis	Convulsions	Heart Murmur	Low Blood Pressure	Sinus Trouble
Anemia	Cortisone Medicine	Heart Pacemaker	Lung Disease	Spina Bifida
Arthritis/Gout	Diabetes	Heart Trouble/Disease	Mitral Valve Prolapse	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Hemophilia	Osteoporosis	Stroke
Artificial Joint	Easily Winded	Hepatitis A	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hepatitis B or C	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Herpes	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	High Blood Pressure	Radiation Treatments	Tuberculosis
Breathing Problems	Excessive Thirst	High Cholesterol	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	Hives or Rash	Renal Dialysis	Ulcers
Cancer	Frequent Headaches	Hypoglycemia	Rheumatic Fever	Venereal Disease
Chemotherapy	Genital Herpes	Irregular Heartbeat	Rheumatism	Yellow Jaundice
Chest Pains	Glaucoma	Kidney Problems	Scarlet Fever	Other (not listed above):_____

FINANCIAL POLICY

FINANCIAL POLICY: We are interested in serving you! Communication and understanding are essential in any professional relationship. Therefore, please make specific financial arrangements with our business staff. Thank you. A service charge of 18% per annum is applied to all accounts with balances over 90 days.
I ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE IN ADVANCE. I AUTHORIZE MY INSURANCE COMPANY TO PAY THE DENTIST ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I FURTHER UNDERSTAND THAT A COLLECTION CHARGE COULD BE ADDED TO ANY OVER DUE BALANCE.

_____
Signature (parent of guardian if minor) Date