Welcome

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

PATIENT INFORMATION (CONFIDENTIAL)

Date ______________________

Name _______________________________________ Birthdate ______________________
(first) (middle) (last)

SS# _______________________________________ Preferred Name ______________________

Address _______________________________________

City ______________________ State ______________________ Zip ______________________

Home Phone ______________________ Work Phone ______________________ Cell ______________________

Email Address _______________________________________

Place of Employment _______________________________________

Appointment Reminder Preference: Home __________ Office __________ Cell __________

May we contact you if an earlier appointment becomes available? ❑ Yes ❑ No

Emergency Contact Person ______________________ Phone ______________________

Please tell us how you learned about us!

❑ Referred By
____

❑ Current Patient
____

PHONE BOOK
❑ Mt. Airy Yellow Pages

❑ Surry Regional Yellow Pages

❑ Elkin Phone Book

❑ Galax/Carroll County, Virginia

❑ Other
Which one(s)?
____

❑ Direct Mail
____

❑ Radio Stations
Which one(s)?
____

❑ Movie Theatres
Which one(s)?
____

❑ Community Event
Which one(s)?
____

❑ Promotional Item
Which one(s)?
____

❑ Outdoor Advertisement
Which one(s)?
____

❑ Internet

❑ Email

SOCIAL MEDIA
❑ Facebook

❑ Instagram

❑ Twitter

❑ YouTube

❑ Other
Which one(s)?
____

INSURANCE INFORMATION (We need a copy of your card)

❑ I/We currently have no dental coverage.

Name of Insured ______________________ Relationship to patient ______________________

SS# ______________________ Birthdate ______________________

Address if different

From above ______________________ City __________ State __________ Zip __________

Name of Employer _______________________________________

Address of Employer ______________________ City __________ State __________ Zip __________

Insurance Company ______________________ Group # ______________________

Insurance Company Address _______________________________________

RESPONSIBLE PARTY

Name of person responsible for the account _______________________________________

Relationship to Patient _______________________________________

Is this person currently being seen in our office? _______________________________________

Address ______________________ City __________ State __________ Zip __________

(PLEASE CONTINUE ON THE BACK)

FORM # drg-3 REV. 3/15

John L. Gravitte, DDS, PA

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Date of last dental visit: ______________________

Previous Dentist? ______________________

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Due to a heart condition, joint replacement, or any other condition, do you need to be pre-medicated prior to dental appointments? ____________
____

Comments: ____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________

140 North Pointe Blvd, Mount Airy, NC 27030 336.719.CARE(2273)

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

_____I understand that during my course of treatment that the following care may be provided. These can include examinations, radiographs, preventative services, restorations, crowns, bridges, root canals, extractions, or other.

2. Drugs and Medications

_____I understand that antibiotics, analgesics (pain medication), and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. Changes in Treatment Plan

_____I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. Insurance

_____I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. I understand that I am responsible for the payment or any balance of the treatment provided.

______________________________ ______________________________
Patient/Guardian Signature Date

Dentistry *with* Heart!

HONESTY QUALITY EMPATHY GENEROSITY STEWARDSHIP TEAMWORK