

CYPRESS LAKE DENTAL ASSOCIATES

PAUL G. GRUMBACH, D.D.S., P.A.

PATIENT INFORMATION

DATE: _____

Name: _____

Primary Address: Street: _____

Unit#: _____ City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Cell: (_____) _____

DOB: ____/____/____ Sex: M / F SS#: _____-_____-_____

IN CASE OF AN EMERGENCY Contact: _____

Relationship: _____ Tel: (_____) _____

Dependent /Minor: Who is responsible for the account?

Name: _____ Relationship: _____

Address: _____

Signature: _____

Insurance: Provide current insurance ID card

Subscriber Name: _____ Relationship to patient: _____

SS#: _____-_____-_____ DOB: ____/____/____ Phone #: (_____) _____

Insurance Co: _____ Subscriber ID#: _____ Group#: _____

Term date of policy: _____ Employer: _____

ASSIGNMENT & RELEASE: I certify that I, and/or my dependent(s) have coverage with:

Insurance Company Name: _____

And assign directly to Dr. Grumbach all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Grumbach may use my dental 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.

Signature: _____ Date: _____

Health History:

Primary Care Doctor: _____ Date of last visit: _____

LIST MEDICATIONS: or attach a list:

Are you taking or scheduled to begin taking a Bisphosphonate i.e., Fosamax, Actonel, Boniva, etc. for Osteoporosis or Paget's disease Yes ____ No ____

ALLERGIES: Please check if applicable I am not aware of any allergies: _____ initial

Aspirin	Codeine	Iodine	Latex	Penicillin	Sleeping Aides	Sulfa
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Other: _____

Aids / HIV	Diabetes	Psychiatric Care
Anemia	Epilepsy / Seizure	Radiation Treatment
Allergy to Novocaine	Emphysema	Respiratory Disease
Angina Pectoris	Excessive Daytime Sleepiness	Rheumatic Fever
Arthritis, Rheumatism	Fainting / Dizzy Spells	Scarlet Fever
Artificial Heart Valves	Frequent Cold Sores	Shortness of Breath
Artificial Joints	Glaucoma	Sinus Trouble
Artificial Heart Valve	Headaches	Skin Rash
Artificial Joints Hip / Knees	Heart Disease	Sleep Disorders/Apnea
Asthma	Heart Murmur	Special Diet
Bleeding Abnormally with Extractions or surgery	Heart Pacemaker	Stent Placement
	Heart Valve Problems	Stroke
Back Problems	Herpes	Swollen Feet or Ankles
Blood Disease	Hepatitis A B C D	Swollen Neck Glands
Bladder Trouble	High / Low Blood Pressure	Thyroid Problems
Blood Transfusions	History of Heart Attack	Tonsillitis
Chemical Dependency	Jaundice	Tuberculosis
Chemotherapy	Jaw Pain	Tumor/Growth on head or neck
Circulatory Problems	Kidney Disease	Ulcer
Congenital Heart Disease	Neurological Problems	Venereal Disease
Cortisone Treatments	Operations	Wear Contact lenses
Cough, persistent or bloody	Osteoporosis	Weight loss, unexplained
Cancer / Tumor	Pacemaker	

Note any disease, condition or problem not listed above: _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed I appropriate by doctor to make a thorough diagnosis _____ initial
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. _____ initial
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications. _____ initial

Signature of Patient/Guardian: _____ Date: _____

<p>History Review:</p> <p>Doctor's Signature: _____ Date: _____</p>
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