CYPRESS LAKE DENTAL ASSOCIATES

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

PATIENT INFORMATION DATE: _____

Name: _____

Primary Address: Street: _____

Unit#:_____City: _____ State: _____ Zip: _____

Secondary Address: _____

Unit#:_____City: _____ State: _____ Zip: _____

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

Work: (_____) _____ E-Mail:_____

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

Occupation: _____ Employer: _____

IN CASE OF AN EMERGENCY Contact: _____

Relationship: _____Tel: (_____) _____

How May we contact you. Please circle

Text Phone Voice Mail E-mail address _____

Who may thank for referring you? _____

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: _____

Oher Physicians you see: _____

	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		Heart Pacemaker		Stent Placement
	Extractions or surgery		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: _____

Have you ever been asked to take an antibiotic one hour before a routine dental visit?

Yes No

Women:

Are you pregnant? yes____ no____ Due Date: _____ Are you nursing? _____

Taking Birth Control pills? Yes_____ No____

LIST MEDICATIONS: or attach a list:

_____

_____

_____

DENTAL HISTORY:

Reason for today's visit: _____

Are there any special concerns or questions: _____

Have you had a panoramic x-ray or a full series of x-rays in the last 3yrs? Had Bitewing x-rays in the last year? Is there any other information that you would like us to procure from your **FORMER DENTIST**?

Name: _____

Address: _____

Phone # _(_____)_____ E-mail _____

Please Check mark to indicate if you have had any of the following:

	Burning sensation on tongue		Food collection between teeth		Periodontal treatment
	Bad breath		Grinding teeth		Sensitivity when biting
	Bleeding gums		Gums swollen or tender		Sensitivity to cold
	Blisters on lips or treatment		Jaw pain or tiredness		Sensitivity to heat
	Broken fillings		Lip or cheek biting		Sensitivity to sweets
	Cigarette or tobacco use		Loose teeth		Sores or growths in mouth
	Chew on one side of mouth		Mouth pain when brushing		
	Clicking or popping jaw		Orthodontic treatment		
	Dry Mouth		Pain around ear		

Are you happy with the appearance of your teeth? Y / N If not Why? _____

How often do you floss your teeth? _____ Water Pic _____ Brush_____

Are you taking or scheduled to begin taking a Bisphosphonate i.e., Fosamax, Actonel, Boniva, etc. for Osteoporosis or Paget's disease Yes _____ No_____

Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates i.e. Reclast, Prolia, etc. for bone pain, hypocalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date treatment began_____ your initials _____

ALLERGIES: Please check if applicable

	Aspirin		Codeine		Iodine		Latex		Penicillin		Sleeping Aides		Sulfa

Other: _____

I am not aware of any allergies: _____initial

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:_____

History Review:

Doctor's Signature: _____ Date: _____