GRIECO

Biological, Cosmetic & Holistic Dentistry

In order for us to give you the best possible treatment, it is important that we get to know you. Although we know that filling out forms is tedious, we must ask that you fill out these forms completely! THANK YOU!

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip_____

Home Phone No. _____ Cell Phone No. _____

Email _____ SSN# _____

Date of Birth _____ Age today _____ Place of Birth _____

Place of Employment & Address _____

Occupation _____ Work Phone No. _____

Marital Status: ____ Single ____ Married ____ Separated _____ Divorced _____ Widow

Spouse's Name (or closest relative) _____ Relationship _____

Spouse's Place of Employment _____

Occupation _____ Work Phone No. _____

Favorite Hobby _____

PLEASE NOTE: The patient is responsible for all fees at the time of service regardless of insurance coverage. We accept cash, personal checks, money orders, Visa, Master Card, and Discover.

Is there anyone we may thank for referring you to our office? Name and address please.

_____

_____

MEDICAL – DENTAL HISTORY

Name _____ Date _____

Date of Last Health Exam _____ Reason for Visit _____

_____

Have you been hospitalized in the past 5 years? _____

Are you currently under the care of a physician? Yes ____ No _____ If yes, for what reason or condition? _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-healing Mouth Sores	No	Yes
Hepatitis (any kind)	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illness	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV/AIDS	No	Yes	Glaucoma	No	Yes
Emphysema or			Liver Disease	No	Yes
Other Respiratory illness	No	Yes	Abnormal Bleeding	No	Yes
Kidney Disease	No	Yes	Unintentional Weight loss/gain	No	Yes
Latex Sensitivity	No	Yes	Heart (Surgery, Disease, Attack)	No	Yes
Venereal Disease	No	Yes	Environmentally Sensitive	No	Yes

Other Serious illness or Disease _____

Are you required to Pre-medicate before dental treatment? No Yes

Woman:

Are you Pregnant? No Yes

Are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you using birth control? No Yes

Are you allergic or have you had a reaction to:

a. Local Anesthetic? No Yes
b. Penicillin or other antibiotics? No Yes
c. Aspirin? No Yes
d. Codeine? No Yes
e. Other medications? _____

Are you a smoker? No Yes If so, how many daily? _____

Did you previously smoke, if so, for how long and when did you quit? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking on the next page of this form.

Please list any herbal supplements/medications you are taking on the next page of this form.

Are you taking blood thinners? No Yes

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take antacids? No Yes If yes, which ones? _____

Do you exercise regularly? No Yes If yes, how often? _____

Do you regularly consume alcoholic beverages? No Yes If yes, how often? _____

Your weight _____

Your height _____

Usual Blood Pressure _____ /_____

Diet:

Restricted diet (i.e. Vegetarian) _____

How many meals a day _____

Food Allergies _____

Sugar in your diet: ___ None ___ Slight ___ Moderate ____ High

MEDICATIONS/SUPPLEMENTS

Please complete the table below regarding your medications/supplements.

Medication/Supplement Name	Prescribed by Who?	Reason for taking this Med/Supp?	How long have you been on Med/Supp?	Dosage