Thank you for visiting **Greystone Smile Design**. We hope to make your visit as pleasant as possible. Please print the form below, fill it out, and bring it to your first appointment.

PATIENT INFORMATION

Patient Name:

First Middle Last Preferred

Address:

Street City State Zip

Personal Information:

Date of Birth Sex Social Security No. Driver License No. State

Contact Information:

Home Phone Work Phone Cell Phone

May we contact you at work? Yes No *May we text you to confirm appointments?* Yes No

Employer Information:

Name of Employer

Employer Address:

Street City State Zip

GREYSTONE SMILE DESIGN

Emergency Contact Information:

Name Relationship Phone

INSURANCE

Primary Dental Carrier:

Subscriber Name Social Security No. Date of Birth

Employer Name Insurance Company Name Insurance Company Phone

Group No. Subscriber's Relationship to Patient

Secondary Dental Carrier:

Subscriber Name

Social Security No.

Date of Birth

Employer Name

Insurance Company Name

Insurance Company Phone

Group No.

Subscriber's Relationship to Patient

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to Greystone Smile Design of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Greystone Smile Design to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature

Date

If patient is under 18:

Name of Responsible Party

Relationship to Patient

Phone

Street Address

City

State

Zip

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ADDITIONAL INFORMATION

What is the reason for today's visit?

How did you hear about Greystone Smile Design?

What would you like to change about your smile?

Are you interested in getting your teeth WHITE?

Why did you leave your last dentist?

What did you like best about your last dentist?

Whom may we thank for referring you?

May we contact you via email? Yes No

Email Address

MEDICAL HISTORY

Mark any you have experienced:

- ○ Abnormal Bleeding
- ○ Alcohol Abuse (or history of)
- ○ Allergies (see allergies section)
- ○ Anemia
- ○ Angina Pectoris
- ○ Arthritis
- ○ Artificial Heart Valve
- ○ Asthma
- ○ Blood Transfusion
- ○ Cancer (what kind ________________)
- ○ Chemotherapy
- ○ Colitis
- ○ Congenital Heart Defect
- ○ Diabetes
- ○ Difficulty Breathing
- ○ Drug Abuse (or history of)
- ○ Emphysema
- ○ Epilepsy
- ○ Facial Surgery
- ○ Fainting Spells
- ○ Fever Blisters
- ○ Frequent Headaches
- ○ Glaucoma
- ○ HIV+ Aids
- ○ Heart Attack (When _______________)
- ○ Heart Murmur
- ○ Heart Surgery
- ○ Hemophilia
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Hepatitis C
- ○ High Blood Pressure
- ○ Joint Replacement
- ○ Kidney Problems
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Mitral Valve Prolapse
- ○ Pace Maker
- ○ Psychiatric Problems
- ○ Radiation Therapy
- ○ Rheumatic Fever
- ○ Seizures
- ○ Sexually Transmitted Disease
- ○ Shingles
- ○ Sickle Cell Disease
- ○ Sinus Problems
- ○ Stroke
- ○ Thyroid Problems
- ○ Tuberculosis
- ○ Ulcers

Allergies:

- ○ Aspirin
- ○ Codeine
- ○ Dental Anesthetics
- ○ Erythromycin
- ○ Latex
- ○ Metals
- ○ Penicillin
- ○ Sulfa
- ○ Tetracycline

Other

Do you smoke? Yes No

How much per day?

How many years have you smoked?

Females:

Are you currently taking birth control?
Yes No

Are you pregnant?
Yes No

If yes, how many weeks?

Are you nursing?
Yes No

Please list any medications you are presently taking and reasons for taking them:

Physician's Information: (if applicable)

Name Phone

Doctor's Notes:

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Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Patient Signature Date

Parent/Guardian Signature Date