James T. Gray, DDS

Partners for Beautiful Healthy Smiles

Patient Information-Confidential

Patient Name_____ Date of Birth_____

Home Address_____
Street City State Zip

Phone#: Home_____ Work_____Cell _____

E-mail_____ Patient Social Security#_____

If a child, parent or guardian's name_____

Employer or School_____ Spouse's name_____

Who Referred You to Our Office?_____

Person Financially Responsible for the Account

Name_____ Marital Status_____

Address_____

Home Phone_____ Work _____Cell _____

E-mail_____ Other contact #_____

Date of Birth_____ Social Security #_____

Driver's License Number_____

How Will This Account Be Paid? ( ) Cash ( ) Check ( ) Credit Card

Dental Insurance Company_____ Group#_____

Address_____ Phone number_____

Employer_____ Occupation_____

In case of an emergency, who should be notified?

Name_____ Relationship_____

Phone Numbers_____

Medical History (Confidential)

Have you been a patient in a hospital during the past five years?	Y	N
Are you under the care of a physician now?	Y	N
Are you taking or have you taken drugs or medicines in the past five years?	Y	N
Have you been told that you need to take antibiotics prior to dental treatment?	Y	N

Please list all medicines you are currently taking: _____

Do you use tobacco?	Y	N
Have you ever taken Phen-Fen/Redux?	Y	N
Have you ever taken Actonel, Boniva, Fosamax, or other Bisphosphonates	Y	N
Do you take anticoagulants/blood thinners? *(Coumadin, Plavix, daily aspirin, ect.)*	Y	N
Are you allergic to or have you had bad reactions to any drugs or medicines?	Y	N

- If yes, please circle or list them below:

Penicillin Erythromycin Sulfa Sedatives Iodine Aspirin Latex Rubber Local Anesthetic
Other:_____

PLEASE CIRCLE if you currently have or have had any of the following?

Anemia	Gastric Reflux	Psychiatric Treatment
Arthritis	Glaucoma	Respiratory Problems
Artificial Heart Valve	Head Injuries	Rheumatic Fever
Asthma	Heart Attack	Seasonal Allergies
Blood Disorders	Heart Disease	Sinus Problems
High Blood Pressure	Heart Murmur	Sleep Apnea
Low Blood Pressure	Cardiac Pacemaker	Snoring
Cancer	Heartburn	STD/HPV
Chemo/Radiation	Hepatitis	Stroke
Chest Pains	HIV/AIDS	Swollen Ankles
Defibrillator	Joint Replacement	Thyroid Problems
Diabetes	Kidney Disease	Tuberculosis
Digestive Problems	Liver Disease	Tumors
Epilepsy	Mitral Valve Prolapse	Ulcers
Fainting/Seizures	Organ Transplant	Other:_____

Women: Are You: Expecting Nursing Taking Oral Contraceptives
Men: Do you take ED medications? Yes No

Name of Physician_____ Phone number_____
Date of Last Physical_____ Vital Signs_____

To the best of my knowledge, all the preceding answers are true and correct. If there is any change in my health or medications I will inform Dr. Gray or his staff at the next appointment.

I authorize Dr. Gray to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child, to third party payers and/or health practitioners. I understand that the fee for dental services is my responsibility and that the amounts paid by dental insurance may be less than the fee for services in this office. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

X

Signature of Patient, Parent, or Guardian

Dental Questionnaire

The more we know about you, the better we can serve you.

Please check the appropriate boxes:

My mouth is… [ ] very comfortable [ ] moderately comfortable [ ] uncomfortable.

I…. [ ] am very pleased with the appearance of my smile.
[ ] am satisfied with the appearance of my mouth.
[ ] am dissatisfied with the appearance of my mouth.

I…. [ ] have set goals for my oral health with my previous dentist.
[ ] am interested in setting goals for my oral health.
[ ] want to fix things as problems occur.

What do you expect from your dentist?_____

_____

Please tell us what is important to you about your dental health. _____

_____

Screening History for TMJ/Jaw Disorder

Do you ever have difficulty opening your mouth?	Y	N
Do you ever hear noises from your jaw joints?	Y	N
Does your jaw ever get stuck, locked or go out?	Y	N
Do you ever have pain in your ears or around your cheeks?	Y	N
Do you ever have pain chewing, yawning or opening wide?	Y	N
Does your bite feel unusual or uncomfortable?	Y	N
Have you ever had trauma to the head or neck?	Y	N
Do you have arthritis in the jaw or neck?	Y	N
Are you aware of grinding or clenching your teeth?	Y	N
Have you ever been treated for TMJ or teeth grinding?	Y	N

James T. Gray DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To the patient - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLLY

I understand that in order to disclose my personal dental information, James T. Gray, DDS Family Dentistry must have my consent. Therefore, I authorize James T. Gray, DDS Family Dentistry to disclose my personal dental information as described on this form, to the recipients listed below: (Example: Physicians other than your referring doctor, family members and insurance companies).

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Ashley Nelson
Telephone: 817-460-4131
E-mail: admin@smilesforlife.com
Address: 901 S. Center St., Arlington, TX 76010

I authorize James T. Gray DDS Family Dentistry to contact me at the following numbers:

Home:_____ Cell: _____ Work: _____

May we leave a message confirming your appointment or regarding any treatment on you answering machine or voicemail? Please circle one: YES NO

By providing my email address in the space below, I authorize James T. Gray DDS Family Dentistry to send my private health information and other electronic communications such as appointment information via E-mail.

Email Address: _____

I authorize James T. Gray, DDS Family Dentistry to disclose my personal dental information or financial information to the recipients listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that when the information is disclosed persuant to this authorization , it may be subject to re-disclosure by the recipient and may no longer be protected. Further, I understand that this consent can be revoked at any time except to the extent that the disclosure in good faith has already occurred in reliance to this consent.

Patient/Representative Signature: _____ Relationship: _____

Date: _____ Witness Signature: _____

Consumer Information: Complaints concerning dental services can be directed to TSBDE.