



NEW PATIENT INFORMATION

Mark B. Griffiths, D.D.S.

Extraordinary Dentistry ~ Exceptional Service

We look forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we may provide the best care possible for you. All information is completely confidential.

PATIENT INFORMATION

Patient's Name _____ Date _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Parent or guardian (if patient is a dependent) _____

Work Phone _____ Cell _____ Email _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Driver's License # _____ Is this person currently a patient in our office? Yes No

Employer _____ Occupation _____ # Years Employed _____

Employer Address _____
Street City State Zip

GETTING TO KNOW YOU

What name do you go by? _____

Is a member of your family or relative a patient of our office? Name _____ Relationship _____

Whom may we thank for referring you to our office? _____

We value the confidence our patients and others place in our office and wish to recognize them for their referrals.)

Person to contact for emergency _____ Phone _____

Address _____
Street City State Zip

Name of nearest relative not living with you _____ Phone _____

Address _____
Street City State Zip

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes / No Are you being treated by a physician now?
If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
6. Yes / No Are you in pain now?
If YES, explain _____

II. Have you experienced any of the following? (Please circle Yes or No for each)

- | | | |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

- | | | |
|--|--|-------------------------------------|
| Yes / No Heart disease | Yes / No Cosmetic surgery | Yes / No Eating disorders |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No Sexual transmitted disease |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of arteries | Yes / No Emphysema or other lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| | | Yes / No Tuberculosis |

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- | | | |
|--|-----------------------|------------------------|
| Yes / No Aspirin | Yes / No Valium | Yes / No Tetracycline |
| Yes / No Darvon | Yes / No Demerol | Yes / No Vicodin |
| Yes / No Codeine | Yes / No Penicillin | Yes / No Percodan |
| Yes / No Latex | Yes / No Food | Yes / No Nitrous oxide |
| Yes / No Local anesthetic
(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal |

Others _____

