Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient's Information

Patient Name:______________________ Date of birth:__________ Age:__________ Sex:______
Home Address:______________________ City:__________________ State:______________ Zip:________
HomePhone:______________________ Bus. Phone:______________________ Cell:__________________
SocialSecurity No.:__________________ Emergency Contact:____________________ Phone:__________________
Email Address:______________________ Referred by:______________________________

Account Information
(Person Financially Responsible for Account)

Name:______________________________ Social Security No:__________________
Relationship to Patient:______________________ Date of birth:__________ Age:__________ Sex:________
Address:______________________________ City:__________________ State:______________ Zip:__________
Home Phone:______________________ Bus. Phone:______________________ Cell:__________________

Dental Insurance

Primary Carrier

Insurance Company______________________ Employer Name:______________________
Insured's Name:______________________ Date of Birth:______________ Relationship to patient:__________
Insured's Social Security No:______________________________

Secondary Carrier

Insurance Company______________________ Employer Name:______________________
Insured's Name:______________________ Date of Birth:______________ Relationship to patient:__________
Insured's Social Security No:______________________________

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (*name of patient*)______________________'s dental needs.

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.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral,written or electronic health records that are individually identifiable as mir for the purposes of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary tc provide quality care will be used or disclosed and that a notice fully outline the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates. I understand that a 1-1/2% late charge (18% APR) may b added to my account. If required, I also understand a check on my credit history may be made.

Patient Signature:______________________________ Date:__________________

Parent/Responsible Party's Signature:______________________ Relationship to Patient:__________

Patient Name:______________________ Date:__/__/____ Patient DOB:___/____/____ Age:_____

Dental History

What is the reason for your visit today? ☐ Examination ☐ Emergency ☐ Consultation

Date of last Dental Visit_________Last Dental Cleaning___________Last Full Mouth Xrays_____________

Is there anything else about having dental treatment that you would like us to know? **YES**☐ **NO**☐

If yes, please describe____

Medical History

Have you been under the care of a medical doctor during the past two years?...................................**Yes** **No**

If yes, for what?____

Physician's Name_________________________________Phone______________________

Have you taken any medications or drugs during the past two years?..**Yes** **No**

Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter Herbal medicines?..**Yes** **No**

Have you ever taken Bisphosphonate Drugs?...**Yes** **No**

Are you aware of having an allergic (or adverse) reaction to any medication or substance?.........................**Yes** **No**

If yes, Please List:____

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Condition		
Heart (Surgery, Disease, Attack)...	**Yes**	**No**
Congenital Heart Disease...........	**Yes**	**No**
Chest Pain.............................	**Yes**	**No**
Heart Murmur..........................	**Yes**	**No**
High Blood Pressure.................	**Yes**	**No**
Mitral Valve Prolapse................	**Yes**	**No**
Artificial Heart Valve................	**Yes**	**No**
Heart Pacemaker......................	**Yes**	**No**
Rheumatic Fever......................	**Yes**	**No**
Arthritis/Rheumatism................	**Yes**	**No**
Swollen Ankles.......................	**Yes**	**No**
Stroke....................................	**Yes**	**No**
Artificial Joints (hip, knee, ect.).....	**Yes**	**No**
Kidney Disease.......................	**Yes**	**No**
Ulcers..................................	**Yes**	**No**
Diabetes.............................	**Yes**	**No**
Thyroid Problems..................	**Yes**	**No**
Glaucoma............................	**Yes**	**No**
Emphysema.........................	**Yes**	**No**
Chronic Cough.....................	**Yes**	**No**
Tuberculosis........................	**Yes**	**No**
Hepatitis A B C (circle)........	**Yes**	**No**
Venereal Disease..................	**Yes**	**No**
AIDS or HIV Positive............	**Yes**	**No**
Cold Sores/ Fever Blisters........	**Yes**	**No**
Blood Transfusion................	**Yes**	**No**
Hemophilia.........................	**Yes**	**No**
Sickle Cell Disease................	**Yes**	**No**
Bruise Easily.......................	**Yes**	**No**
Liver Disease or Jaundice........	**Yes**	**No**
Neurological Disorders...........	**Yes**	**No**
Epilepsy or Seizures..............	**Yes**	**No**
Fainting or Dizzy Spells..........	**Yes**	**No**
Nervous/Anxious..................	**Yes**	**No**
Psychiatric/Psychological Care..	**Yes**	**No**
Asthma..............................	**Yes**	**No**
Latex Sensitivity..................	**Yes**	**No**
Allergies or Hives.................	**Yes**	**No**
Sinus Trouble......................	**Yes**	**No**
Radiation Therapy................	**Yes**	**No**
Chemotherapy......................	**Yes**	**No**
Tumors..............................	**Yes**	**No**

Have you lost or gained more than 10 pounds in the past year?...**Yes** **No**

If yes, was this loss or gain intentional?..**Yes** **No**

Do you have any disease, condition, or problem not listed?..**Yes** **No**

If yes, please list:____

Women (Please Check) ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

X **Patient/Guardian Signature**_____________________________________Date:______________

Reviewed by Doctor____________________________________Date:______________BP:__________

David M. Griffith, D.D.S. **260-894-4044**

APPOINTMENT INFORMATION

We would like to thank you for choosing our office for your dental needs, and we look forward to working with you and your family and friends.

Our office is dedicated to providing you with the best dental care possible, and in order to do this we need your help! By following the guidelines below, we will be able to better serve you and to keep timely appointments.

All appointments must be confirmed. If you have not confirmed your appointment by 6:00 p.m. the day prior to the appointment, and we have not been able to reach you (IN PERSON) by phone, this is considered a **broken appointment**, and another patient will be given the appointment time.

After one (1) broken appointment-We will reschedule with the understanding you recommit to the appointment policy.

After two (2) broken appointments-You will be placed on a walk-in only basis, schedule permitting.

If a change needs to be made in appointment time, please call **260-894-4044** by **6:00 p.m.** the day before and we will gladly give you a time that will work for you.

If you arrive more than 10 minutes late to your scheduled appointment, we reserve the right to reschedule you.

Signature of Patient/Parent/Guardian:

_______________________________________ **DATE:**__________

I have read the above guidelines and have been given a copy for my records.

907 LINCOLNWAY SOUTH
LIGONIER, IN 46767
(260) 864-4044
FAX: (260) 894-4043

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, ________________________, Date of Birth:__________________, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), test results, dates of service.

PLEASE CHECK ALL THAT APPLY

☐ You may disclose information to my family members and or non-family members. Please list name, phone number, and relationship.

Name	Phone Number	Relationship

☐ You may leave Protected Health Information on my answering machine/ voicemail.

Phone Number:____

☐ Other:____

☐ You may disclose insurance information to a referring dental office.

Patient's Signature:____________________________ Date:________________

____________________________________ ________________________
Patient's Printed Name Date

____________________________________ ________________________
Patient's Signature (or Guardian, if Minor) Date

____________________________________ ________________________
Witness (Optional) Date