GIANNINI | GRAY DENTAL PARTNERS

EUGENE T. GIANNINI, DDS
BRIAN J. GRAY, DDS

4801 WISCONSIN AVENUE, NW, SUITE 200, WASHINGTON, DC 20016
P: 202.244.4111 **F:** 202.244.6389

PATIENT INFORMATION

TODAY'S DATE ______

NAME

FIRST MIDDLE LAST HOW YOU WOULD LIKE TO BE ADDRESSED?

HOME ADDRESS

EMAIL ADDRESS

TEXT REMINDERS
- YES
- NO

ARE ANY FAMILY MEMBERS PATIENTS WITH US? WHO?

PHONE HOME ______

BUSINESS ______

CELL ______

WHOM MAY THANK FOR REFERRING YOU?

EMPLOYER/OCCUPATION

SOCIAL SECURITY #

BIRTHDATE

MARITAL STATUS
- SINGLE
- MARRIED
- DIVORCED
- WIDOWED

SEX
- MALE
- FEMALE

INSURANCE & BILLING INFORMATION

We provide the courtesy of filing your insurance claims on your behalf. Please provide us with your insurance id card at time of registration.

PERSON RESPONSIBLE FOR ACCOUNT

EMPLOYER NAME

RELATION TO PATIENT

DENTAL INSURANCE COMPANY

DATE OF BIRTH SOCIAL SECURITY #

GROUP NUMBER DENTAL ID #

DENTAL HISTORY

REASON FOR TODAY'S VISIT

FORMER DENTIST

DATE OF LAST DENTAL CARE

PLEASE READ THE FOLLOWING

- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**
- **I understand that a fee may be charged for broken appointments as well as appointments canceled with less than 24 hour notice.**
- **I authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or insurance company to secure payment of benefits.**
- **I understand that all professional services are charged directly to the patient and that I am responsible for payment of fees including all collection/attorney fees.**

RESPONSIBLE PARTY NAME SIGNATURE DATE

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MEDICAL HISTORY

TODAY'S DATE ______

MEDICAL DOCTOR'S NAME ______

DATE OF LAST VISIT WITH MEDICAL DOCTOR ______

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS WITH 5 YEARS?
- ☐ YES, DESCRIBE WITH DATES ☐ NO

HAVE YOU EVER HAD A BLOOD TRANSFUSION?
- ☐ YES, DESCRIBE WITH DATES ☐ NO

WOMEN:
- ARE YOU PREGNANT? ☐ YES ☐ NO
- NURSING? ☐ YES ☐ NO
- TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ☐ AIDS/HIV POSITIVE
- ☐ ANEMIA
- ☐ ARTHRITIS, RHEUMATISM
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BACK PROBLEMS
- ☐ BISPHOSPHONATE
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CHEMO/RADIATION THERAPY
- ☐ CIRCULATORY PROBLEMS
- ☐ CORTISONE TREATMENTS
- ☐ COUGH, PERSISTENT
- ☐ COUGH UP BLOOD
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HEADACHES
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS, DESCRIBE ______
- ☐ HEMOPHILIA
- ☐ HEPATITIS A/ B /OTHER
- ☐ HIGH BLOOD PRESSURE
- ☐ JAW PAIN
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MITRAL VALVE PROLAPSE
- ☐ NERVOUS PROBLEMS
- ☐ PACEMAKER
- ☐ PSYCHIATRIC CARE
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SKIN RASH
- ☐ STROKE
- ☐ SWELLING OF FEET/ANKLES
- ☐ THYROID PROBLEMS
- ☐ TOBACCO HABIT
- ☐ TUBERCULOSIS
- ☐ ULCER
- ☐ VENEREAL DISEASE

MEDICATIONS

LIST MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING IE. HERBAL, VITAMINS

______

______

ALLERGIES

- ☐ ASPIRIN
- ☐ CODEINE
- ☐ PENICILLIN
- ☐ SULFA
- ☐ LATEX
- ☐ LOCAL ANESTHETIC
- ☐ OTHER

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH THAT WE HAVE NOT COVERED ON THIS FORM?

______

______

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED? IF SO, EXPLAIN

______

______

PRINT NAME ______

PATIENT SIGNATURE ______ DATE ______

DOCTOR SIGNATURE ______ DATE ______