GriecoDentistry™
healthy smiles. naturally.

EMERGENCY DENTAL & REGISTRATION TREATNENT

WHITE

Patient Name _____ Todays Date _____
LAST FIRST MIDDLE INITIAL

Soc. Sec. # _____ Birthdate _____ Age _____ Sex ☐ M ☐ F

Adddress _____ city _____

State _____ Zip _____ home phone: _____ cell phone: _____

I prefer to be contacted at: ☐ Home ☐ work ☐ Cell Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Other _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

In case of an emergency, who should we contact: _____ Phone: _____

Person Responsible to Account _____ Relationship to this person _____

NOTE TO PATIENTS WITH DENTAL INSURANCE

Dr. Grieco does not participate with any insurance companies and is considered to be out of network dentist by your dental plan. **In most cases, you will still be able to receive benefits from your dental insurance.** If you are concerned about what will and will not be covered, is your responsibility to contact the company. We require that you either pay your bill, info, at the time of service or make financial arrangements with the financial advisor beforehand. We offer payment options for any treatment over $350. Our office will fill out all the necessary paperwork for your insurance company. It is your responsibility to submit the paperwork needed to receive your benefits. Insurance company will then send the reimbursement check directly to you. Please present your dental insurance card to the person at the front desk so that we may properly complete your paperwork.

Attention patients under medical assistance or with Medicare, Medicaid, or Security Blue.

Dr. Grieco is not a provider with any of these programs. Therefore, you will not receive any benefits from the dental plan, provided through these programs, should you have treatment done at our office. If you wish to become a patient with Dr. Grieco we will be very happy to have you, but please keep in mind that you will be responsible to pay your bills in full and at the time of service.

MEDICAL HISTORY

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, IT IS PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE BEEN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING.

	YES	NO
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illness or operations?	☐	☐
Please explain: _____		
3. Are you currently taking any medication?	☐	☐
Please explain: _____		
4. Do you use tobacco products?	☐	☐
5. Do you or have you used controlled substances?	☐	☐
6. Do you wear contact lenses?	☐	☐
7. Are you allergic to or have you had reactions to:		
Local and aesthetics like Novocain or Carbocaine	☐	☐
Penicillin or other Anitbiotics (list) _____	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives or Sleeping Pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any Metals (e.g. Nickel, Mercury)(list) _____	☐	☐
Latex / Rubber	☐	☐
Other (Please List) _____	☐	☐
8. Do you or have you ever had any of the following:		
Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Heart Defect or Heart Murmur	☐	☐
Organ Transplant or Joint Replacement / Implant	☐	☐
Mitral Valve Prolapse	☐	☐

	YES	NO
Congenital Heart Problem	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
Anemia	☐	☐
Cold Sores / Fever Blister	☐	☐
Epilepsy or Seizures	☐	☐
Sexually Transmitted Disease	☐	☐
AIDS or HIV Infections	☐	☐
Chemotherapy (Cancer, Leukemia)	☐	☐
Mental Health Care	☐	☐
Chemical Dependency	☐	☐
Eating Disorders	☐	☐
9. Is there any other health conditions, which are not listed above, that we should be aware of?	☐	☐
Please list: _____		
10. Have you ever been instructed to premedicate prior to dental appointments?	☐	☐
If YES, what antibiotic were you prescribed? _____		
11. (WOMEN ONLY) Are you:		
Pregnant or Think you may be pregnant	☐	☐
Nursing	☐	☐
Taking birth control	☐	☐