



Granite Family Dentistry
 1558 Hooksett Road, Hooksett, NH 03106
 Phone (603)485-4855 FAX (603)485-2500
 Website: www.granitefamilydentistry.com

Medical Alert for Office Use

Thank you for visiting Granite Family Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Date: _____

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP BIRTH DATE

Employer _____ E-mail _____

Occupation _____ Best time and place to reach you? _____

Phone: Home () _____

Work () _____

Mobile () _____

May we contact you at work? Yes No

Male Female Married Single

Emergency Name _____ Phone () _____

Insurance Information

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____ Subscriber # _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____ Subscriber # _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to Granite Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Granite Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If patient is under 18 – we do not get involved in third party billing – payment is due at the time of service.

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone () _____

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

When was your last dental exam and cleaning? _____

Medical History and Information

Physician: _____ Date and Reason for last visit: _____

Conditions

- Abnormal Bleeding
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Asthma
- Back problems
- Blood Transfusion
- Cancer
- Celiac Disease
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- GERD
- Glaucoma
- HIV /AIDS
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Herpes
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Osteoporosis or History
- Pacemaker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N
 Do you Smoke or use Tobacco? How much? _____

Y N
 Do you consume alcohol? How much? _____

If Female:
Y N
 Are you taking Birth Control Pills?
 Are you pregnant?
If yes, # of weeks _____
 Are you nursing?

Please list any medications you are currently taking: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility at the time of service.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE