DR. JAMES B. GRAY, DMD, PC 10930 CRABAPPLE ROAD SUITE 240 | ROSWELL, GA 30075 | 770.993.6292

DATE: _____

PATIENT'S FULL NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐ F ☐ M

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

CELL PHONE: _____ HOME PHONE: _____

EMPLOYER/OCCUPATION _____ HOW LONG WITH THIS EMPLOYER? _____

SPOUSE'S NAME: _____ CELL #: _____ EMPLOYER: _____

PREFERRED COMMUNICATION METHOD: ☐ PHONE ☐ TEXT ☐ E-MAIL

PREFERRED E-MAIL ADDRESS: _____

DENTIST: _____ DATE OF LAST DENTAL VISIT: _____

REFERRED BY: ☐ DENTIST _____ (if different from above) ☐ FRIENDS _____ (please specify) ☐ INTERNET _____ (i.e Google, Healthgrades, Facebook)

☐ OTHER _____

PERSONAL INTERESTS / ACTIVITIES: _____

DO YOU ANTICIPATE A MOVE IN THE NEAR FUTURE? ☐ Y ☐ N IF YES, WHERE? _____

MEDICAL HISTORY INFORMATION

☐ Y ☐ N HEART DISEASE
☐ Y ☐ N ASTHMA
☐ Y ☐ N BLEEDING DISORDER
☐ Y ☐ N DIABETES
☐ Y ☐ N HEPATITIS
☐ Y ☐ N RHEUMATIC FEVER
☐ Y ☐ N FAINTING OR DIZZINESS
☐ Y ☐ N ACID REFLUX
☐ Y ☐ N HORMONES
☐ Y ☐ N EMOTIONAL DISORDER
☐ Y ☐ N EPILEPSY
☐ Y ☐ N OSTEOPOROSIS
☐ Y ☐ N ARTHRITIS
☐ Y ☐ N TONSILLECTOMY (YEAR:_____)
☐ Y ☐ N ADENOIDECTOMY (YEAR:_____)

IF YOU CHECKED YES ABOVE, PLEASE EXPLAIN: _____

PLEASE LIST ANY OTHER MEDICAL INFORMATION OR HISTORY THAT MAY BE HELPFUL: _____

_____ PHYSICIAN: _____

MEDICATIONS NOW BEING TAKEN/REASONS: _____

ARE YOU CURRENTLY TAKING PRESCRIPTION PAIN PILLS OR NSAIDS? ☐ Y ☐ N

ALLERGIES / SENSITIVITIES: _____

DENTAL & ORTHODONTIC HISTORY INFORMATION

HAVE ANY TEETH BEEN REMOVED BY THE DENTIST? ☐ Y ☐ N

HAVE YOU SUSTAINED ANY INJURIES TO THE FACE, HEAD, OR TEETH? ☐ Y ☐ N

IF YES, PLEASE EXPLAIN: _____

HAVE YOU BEEN TREATED BY A PERIODONTIST? ☐ Y ☐ N IF YES, NAME OF PERIODONTIST: _____

IF YES, PLEASE DESCRIBE TREATMENT _____

DESCRIBE ORAL HABITS (I.E. GRINDING OF TEETH, NAIL BITING, ETC) _____

DO YOU HAVE PAIN, POPPING, GRATING, OR CLICKING NOISES IN YOUR JAW JOINTS? ☐ Y ☐ N

IF YES, PLEASE EXPLAIN _____

DO YOU EXPERIENCE? ☐ Y ☐ N DAYTIME SLEEPINESS

☐ Y ☐ N SNORING

IS ORTHODONTICS A NEW EXPERIENCE FOR YOU? ☐ Y ☐ N

IF NO, PLEASE EXPLAIN _____

HAVE YOU EVER BEEN EVALUATED BY ANOTHER ORTHODONTIST? ☐ Y ☐ N

PLEASE LIST YOUR CHIEF CONCERNS & COMMENTS ABOUT YOUR TEETH IN THE SPACE PROVIDED BELOW.

_____

_____

WHICH MOST CLOSELY DESCRIBES YOUR PERSONALITY? ☐ RESERVED ☐ OUTGOING ☐ NERVOUS ☐ ACTIVE ☐ ARTISTIC

IF NECESSARY, WOULD YOU CONSIDER WEARING BRACES? ☐ Y ☐ N

ARE YOU FAMILIAR WITH THE BENEFITS OF SURESMILE® TECHNOLOGY? ☐ Y ☐ N

ARE YOU FAMILIAR WITH WILKODONTICS®? ☐ Y ☐ N

ARE YOU FAMILIAR WITH INVISALIGN®? ☐ Y ☐ N

OTHER COMMENTS/CONCERNS _____

_____

I, _____, HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. IF THERE ARE ANY CHANGES TO THESE HISTORY RECORDS OR MEDICAL/DENTAL STATUS, I WILL INFORM THIS PRACTICE.

SIGNATURE: _____ DATE: _____

DENTAL INSURANCE INFORMATION

IS THE PATIENT COVERED BY DENTAL INSURANCE? ☐ Y ☐ N

IS THE PATIENT COVERED BY ORTHODONTIC INSURANCE? ☐ Y ☐ N ☐ UNSURE (if yes or unsure, please give your dental insurance card to the front desk)

PATIENT'S FULL NAME: _____ DATE OF BIRTH: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S ADDRESS: _____
(IF DIFFERENT FROM PATIENT'S ADDRESS)
(STREET) (CITY) (STATE) (ZIP)

ID NUMBER OR SOCIAL SECURITY NUMBER: _____ GROUP NUMBER: _____
(NEEDS TO BE NINE DIGITS OR MORE)

EMPLOYER/COMPANY NAME: _____

DENTAL INSURANCE COMPANY: _____

INSURANCE CO. PHONE NUMBER: _____

INSURANCE CO. ADDRESS: _____
(STREET) (CITY) **(STATE)** (ZIP)

EFFECTIVE DATE:

~ FOR OFFICE USE ONLY ~

DATE CHECKED: _____ CHECKED BY: _____ CONTACT PERSON: _____

LTM: $ _____ YEAR / LIFETIME PAID AT: _____ % DEDUCT: $ _____

AMT USED TO DATE: _____ AMT REMAINING TO DATE: _____

AGE LIMIT: _____ NEED TO PRE-AUTHORIZE? ☐ Y ☐ N

HOW IS BENEFIT PAID? MONTHLY / QUARTERLY / 2 PAY PLAN / ANNUAL / OTHER

WE BILL OR AUTO

COMMENTS: _____

WORK IN PROGRESS? ☐ Y ☐ N ELECTRONIC PAYER ID #: _____

_____ I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.
INITIALS

_____ I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO DR. JAMES B. GRAY DMD, PC.
INITIALS

SIGNATURE: _____ DATE: _____