KENNETH E. GRINDLAY, D.D.S., P.C. PATIENT HEALTH HISTORY

DATE:					
Patient Name:			Date of Birth:		
Best Number to Contact You:					
Emergency Contact Name:	Phone Number:Relationship:				
PLEASE FILL IN ALL BLANKS AND/OR A	ANSWE	R YES O	R NO		
Are you under the care of a physician? YI					
Is so, who and what for Have you been hospitalized, has a serious	illness	, or had a	any surgery? YES NO		
If so, what was the problem?					
Do you have or have you had any of the fo	ollowin	g?			
Rheumatic Fever	YES	NO	Arthritis	YES	NO
Congenital Heart Disease	YES	NO	Cough	YES	NO
Heart Trouble of Any Kind Including:	YES	NO	Sinus Problems	YES	NO
Heart murmur, Heart attack, Surgery, Ang	gina,		HIV Positive/AIDS	YES	NO
Pacemaker, Mitral valve prolapse, Arterio	scleros	sis	Artificial Joint/Implant/Heart Valve	YES	NO
Stroke	YES	NO	Pins/Screws/Plates		
Cancer	YES	NO	Date of Surgery:	YES	NO
Have you ever had radiation treatment?	YES	NO	Blood Transfusion	YES	NO
Allergy or Hayfever	YES	NO	Diabetes	YES	NO
Asthma or Bronchitis	YES	NO	Do you have excessive thirst or urination?	YES	NO
Epilepsy, Seizures, or Fainting Spells	YES	NO	Do you have any healing problems?	YES	NO
Hepatitis, Jaundice, or Liver Disease	YES	NO	Anemia	YES	NO
Ulcers	YES	NO	Kidney Disease/Dialysis	YES	NO
Tuberculosis	YES	NO	Venereal Disease	YES	NO
High or Low Blood Pressure	YES	NO	Women Only: Are You Pregnant?	YES	NO
Glaucoma	YES	NO	women omy. The Tou Freguenc.	113	110
ARE YOU TAKING ANY MEDICATIONS? P. PLEASE LIST: Medications and Condition			Over the Counter: YES NO		
Are you ALLERGIC to any of the following	•	NO	Destablishment of the conflict of	VEC	NO
Latex Local Anesthetics	YES YES	NO NO	Penicillin or other antibiotic Aspirin	YES YES	NO NO
Sulfa Drugs	YES	NO NO	Codeine	YES	NO NO
Iodine	YES	NO	Other:		
Please add anything else you feel is impor	rtant:				
Patient/Parent Signature					
	CON	ITINUED	CARE VISITS		
Date: Changes:	Patient Signature:				
Date: Changes:	Patient Signature:				
Date: Changes:		Patient Signature:			
Date: Changes:		Patient Signature:			

KENNETH E. GRINDLAY, D.D.S., P.C. 228 MT. PLEASANT RD. CHESAPEAKE, VA 23322

PATIENT RECORD

Patient Name: City: State: ZIP: Home Phone: Work Phone: Marital Status: Date of Birth: Sex: Occupation: Employer: Employer: Employer Address: Sex: Occupation: Employer: Employer: Employer Address: Sobscriber: Marital Status: Date of Birth: Sex: Occupation: Sobscriber Information: Name: Address: Subscriber Information: Name: Date of Birth: SSN: Employer: SECONDARY DENTAL INSURANCE (if applicable) Name of Insurance: Address: Subscriber: SSN: Employer: Address: Subscriber Information: Name: Date of Birth: SSN: Employer: SSN: Employer: Relationship to Subscriber: SSN: Employer: Relationship to Subscriber: SSN: Employer: Address: Subscriber Information: Name: Date of Birth: SSN: Employer: Address: Subscriber: SSN: Employer: Relationship to Subscriber: SSN: Employer: Address: Subscriber: SSN: Employer: Sobscriber: SSN: SSN: Employer: Sobscriber: SSN: SSN: SSN: SSN: SSN: SSN: SSN: SS	Date:	_		
Home Phone: Cell Phone: Work Phone: Marital Status: Date of Birth: Sex: Occupation: Employer: Employer Address: DENTAL INSURANCE Name of Insurance: Date of Birth: SSN: Relationship to Subscriber: SECONDARY DENTAL INSURANCE (if applicable) Name: Date of Birth: SSN: Employer: Relationship to Subscriber: SSN: Employer: Relationship to Subscriber: Address: SSN: Employer: Relationship to Subscriber: Relationship to Subscriber: Address: SSN: Employer: Relationship to Subscriber: Relationship to Subscriber: Aminimum charge may be made for failed or canceled appointments without prior notification of 24 hours. The fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still have to be paid whenever you are present or not. Once an appointment is made please remember this time has been reserved for you. ***********************************	Patient Name:		SSN:	
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Employer:	Marital Status: Date of	f Birth: Sex:	Occupation:	
Name of Insurance:	Employer:	Employer Addr	ess:	
Name of Insurance:		DENTAL INCLIDAN	יםר	
Subscriber Information: Name:	Name of Insurance:			
Name:	Subscriber Information:			
SECONDARY DENTAL INSURANCE (if applicable) Name of Insurance: Address:	Name:	Date of Birth:	SSN:	
SECONDARY DENTAL INSURANCE (if applicable) Name of Insurance:				
Name of Insurance:	2proyer	Rolderor	isimp to subscriber.	
Subscriber Information: Name:	SECO	NDARY DENTAL INSURANC	E (if applicable)	
Name: Date of Birth: SSN:	Name of Insurance:	Addre	ess:	

**************************************	Name:	Date of Birth:	SSN:_	
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available upon request.	notification of 24 hours. The electric, heat, etc., which stappointment is made please **********POLICY ON BILL We request that pay dental insurance, as a cour estimate your financial lial insurance coverage is differ that part of treatment not Except in cases whe receipt of a billing statement unpaid balance. In the even account is placed in the hawill be charged an addition attorney fees and court cost.	the fee covers only a portion of till have to be paid whenever se remember this time has be LED TREATMENT AND ASSIGNATION ASSIGNATION OF THE SET OF THE SE	of the overhead such a you are present or neen reserved for you. GNEMENT OF INSURA as treatment progress le your insurance. We say the week, since each lexact cost of treatment upon its determination to be been made, payment of any amount	as salaries, ot. Once an ANCE******** Ses. If you have will try to individual ent, Payment for on. It is due upon sed to any at due, and your egal action, you ency and insactions.
Signature: Date:	Signature:		Da	te: