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 ANSWER YES OR NO
Are you under the care of a physician? YES NO
Is so, who and what for_____
Have you been hospitalized, has a serious illness, or had any surgery? YES NO
If so, what was the problem?_____

Do you have or have you had any of the following?

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, Angina, Pacemaker, Mitral valve prolapse, Arteriosclerosis			HIV Positive/AIDS	YES	NO
			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			

ARE YOU TAKING ANY MEDICATIONS? Prescriptions or Over the Counter: YES NO
PLEASE LIST: Medications and Conditions taken for:
_____
_____

Are you ALLERGIC to any of the following

Latex	YES	NO	Penicillin or other antibiotic	YES	NO
Local Anesthetics	YES	NO	Aspirin	YES	NO
Sulfa Drugs	YES	NO	Codeine	YES	NO
Iodine	YES	NO	Other:_____		

Please add anything else you feel is important:_____

Patient/Parent Signature_____

CONTINUED 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

Date:_____

Patient Name:_____ SSN:_____
Address:_____ City:_____ State:_____ ZIP:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Marital Status:_____ Date of Birth:_____ Sex:_____ Occupation:_____
Employer:_____ Employer Address:_____

DENTAL INSURANCE

Name of Insurance:_____ Address:_____
Subscriber Information:
Name:_____ Date of Birth:_____ SSN:_____
Employer:_____ Relationship to Subscriber:_____

SECONDARY DENTAL INSURANCE (if applicable)

Name of Insurance:_____ Address:_____
Subscriber Information:
Name:_____ Date of Birth:_____ SSN:_____
Employer:_____ Relationship to Subscriber:_____

**********FAILED/CANCELED APPOINTMENT POLICY**********

A minimum 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.

**********POLICY ON BILLED TREATMENT AND ASSIGNEMENT OF INSURANCE**********

We request that payment for services be made as treatment progresses. If you have dental insurance, as a courtesy to you, our office will file your insurance. We will try to estimate your financial liability before treatment starts. However, since each individual insurance coverage is different, we cannot provide and exact cost of treatment, Payment for that part of treatment not covered by insurance is due upon its determination.

Except in cases where financial agreements have been made, payment is due upon receipt of a billing statement. A 1½ % monthly interest charge may be assessed to any unpaid balance. In the event that there is a default of payment of any amount due, and your account is placed in the hands of an agency or an attorney for collection or legal action, you will be charged an additional fee equal to the cost of collection including agency and attorney fees and court costs incurred permitted by law governing these transactions.

The undersigned agrees to this and acknowledges that a copy of this form was made available upon request.

Signature: _____ Date:_____