CHARLES GRIFF, M.D. PEGGY HUNTER, M.D. DANA COLLIER HOLL, M.D.

PERSONAL INFORMATION

NAME _____ DATE OF BIRTH ____ /____ /____ AGE _____ SEX _____

STREET ADDRESS _____ APT # _____ CITY _____

STATE _____ ZIP CODE _____ SOCIAL SEC. NUMBER _____

NORTHERN ADDRESS _____ CITY _____ ST _____ ZIP CODE _____

NORTHERN PHONE NUMBER _____

IN CASE WE NEED TO REACH YOU, REGARDING YOUR LAB WORK OR BIOPSY RESULTS OR TO CONFIRM AN APPOINTMENT

PLEASE WRITE IN YOUR DAYTIME PHONE NUMBER HERE: _____

HOME PHONE # _____ **ALT. PHONE #** _____ **CELL PHONE #** _____

ARE YOU SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____

NAME OF REFERRING PHYSICIAN/PERSON _____ **PHONE** _____

NAME OF YOUR PERSONAL PHYSICIAN _____ **PHONE** _____

NAME OF PHARMACY _____ **PHARMACY PHONE NUMBER** _____

EMPLOYEE INFORMATION

EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____

FULL TIME _____ PART TIME _____ RETIRED _____ SELF _____ MILITARY _____ UNEMPLOYED _____ DISABLED _____

PARENT-SPOUSE-RELATIVE OR FRIEND INFORMATION (IN CASE OF AN EMERGENCY)

NAME _____ ADDRESS _____

HOME PHONE _____ WORK PHONE _____ RELATION _____

INSURANCE INFORMATION (PERSONAL INFORMATION of card holder) **********

FIRST AND LAST NAME OF **PRIMARY** INSURANCE HOLDER _____ RELATION TO PATIENT _____

DATE OF BIRTH OF PRIMARY HOLDER ____ /____ /____ PRIMARY HOLDER'S SS # _____

PRIMARY INSURANCE HOLDER'S HOME ADDRESS _____

PLEASE CHECK IF THE PATIENT IS A **FULL TIME** STUDENT ____ OR **PART TIME** STUDENT ____ NAME OF SCHOOL _____

MEDICAL HISTORY

WHAT BRINGS YOU HERE TODAY? _____

HOW IS YOUR GENERAL OVERALL HEALTH? _____

DO YOU TAKE ANTIBIOTICS BEFORE A DENTAL PROCEDURE OR DO YOU HAVE A HEART MURMUR, ARTIFICIAL HEART VALVE, JOINT, OR PROSTHESIS?

YES ____ NO ____

PLEASE LIST ALL MEDICATIONS: _____

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? _____

PLEASE LIST ALL MEDICAL PROBLEMS: _____

PLEASE CHECK IF POSITIVE OR HISTORY OF:

☐ DIABETES	☐ TUBERCULOSIS	☐ ASTHMA / HAY FEVER	☐ HEPATITIS	☐ HEART / LUNG
☐ PEPTIC ULCER	☐ HYPERTENSION	☐ HIVES / ECZEMA	☐ ANEMIA	☐ LIVER
☐ KIDNEY	☐ CANCER	☐ ARTHRITIS	☐ SKIN CANCER	☐ HIV + OR EXPOSURE

☐ ARE YOU ON A BLOOD THINNER

LIFETIME AUTHORIZATION: I hereby authorize direct payment of surgical and medical benefits to Dr. Griff/Dr. Hunter/Dr. Holl for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Dr. Griff/Dr. Hunter/Dr. Holl to release any medical and incidental information that may be necessary for either medical care or in processing application for financial benefits. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. A photocpy of these assignments shall be valid as the original.

SIGNATURE* _____ ***DATE*** _____

PATIENT'S NAME _____ ***PARENT/GUARDIAN*** _____