Gregory J Gorman DMD LLC
1301 North 7th Street, Suite A
Grand Junction, CO 81501

DENTAL SERVICES AGREEMENT & PATIENT INFORMATION FORM

NAME_____ Name I prefer to be called:_____
Last First Middle

HOME ADDRESS_____
Street City State Zip

❑ Married ❑ Minor ❑ Single ❑ Widowed ❑ Divorced ❑ Separated Social Security No._____

PHONE: Home_____ Work_____ Cell_____

DATE OF BIRTH_____ Whom may we thank for referring you?_____

EMPLOYER_____ Occupation_____ Length of Employment_____

EMPLOYER ADDRESS_____
Street City State Zip

PERSON RESPONSIBLE FOR ACCOUNT_____ Social Security Number_____

ADDRESS_____ PHONE_____

EMPLOYER NAME & ADDRESS_____

NEAREST LOCAL RELATIVE OR FRIEND WE MAY CONTACT IN CASE OF AN EMERGENCY: Name_____

Relation_____ Phone: Home_____ Work_____ Cell_____

Name of Dental Insurance_____ Group Number _____

DENTAL HISTORY

1. Reason for this visit:_____
2. Previous dentist:_____ Date Last Treated:_____

3.	Are you having pain at this time?	Yes	No	7. Is it important to you to keep your teeth?	Yes	No
4.	Do you suffer pain and or swelling of your gums?	Yes	No	8. Are you satisfied with the appearance of your teeth?	Yes	No
5.	Do your gums often bleed when you brush your teeth?	Yes	No	9. Do you have mouth dryness?	Yes	No

6. Problems of the jaws. Have you ever experienced any of the following? (Please Circle) Yes No
   a) clicking of the jaw? b) pain (joint, ear, side of face)?
   c) difficulty in opening and closing? d) difficulty in chewing?
10. Is there anything about having dental treatment that bothers you? Yes No

If so, please explain_____

MEDICAL HISTORY

1. Name of physician(s):_____ Date of last Physical exam:_____
2. Are you taking any drugs for osteoporosis? Yes No

   If so, please list each one_____
3. Provide us with a list of all current prescription and non prescription medications on back of this page.
4. Are you allergic or sensitive to aspirin, penicillin, latex, dental anesthetics, codeine or any other drugs? Yes No

   If so, please explain_____
5. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No

   If so, please explain_____
6. Women: Are you pregnant? If so, delivery date_____ Yes No
7. Do you have or have you had any of the following diseases or problems? (please circle)

rheumatic fever	heart disease	hepatitis	jaundice	cancer	sexually transmitted disease
congenital heart lesions	chest pain	liver or kidney disease	asthma, emphysema	radiation treatment	sensitivity to heavy metals
high blood pressure	heart attack	thyroid disease	epilepsy	tumor history	sinus trouble
rheumatic heart disease	heart murmur	allergy	seizures, fainting	stomach ulcers	glaucoma
artificial heart valve	pacemaker	arthritis	tuberculosis	H.I.V. positive	joint replacement
mitral valve prolapse	stroke	diabetes	anemia	A.I.D.S.	osteoporosis

8. Have you had any other serious illness or operation? Yes No

   If so, what?_____

CONSENT: The signature of patient or guardian below acknowledges and authorizes the work, fee and completion of all agreed dental services and use of methods appropriate thereto. This agreement and consent shall remain in effect until cancelled by either party. If legal services are obtained to enforce this agreement, patient or guardian shall be responsible for the payment of all dental fees, Dentist's attorney's fees, court costs and costs of collection.

SIGNATURE_____ DATE_____
Patient, Parent or Guardian

Medication Profile

Please list all prescription medications, over-the-counter medications, and herbal supplements that you are currently taking.

Name of Medicine	Prescribed for	Date Reviewed