



Kevin C. Granger, D.D.S., P.C.

8363-B GREENSBORO DRIVE
Mc LEAN, VA 22102

TELEPHONE: (703) 790-5533
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Instructions: For all new patients (and for returning patients whose insurance, contact or medical information has changed). Please print, complete and bring in with you.

PATIENT INFORMATION AND MEDICAL RECORD

PATIENT

Name: _____ Age: _____
Male: _____ Female: _____ Date of Birth: _____ Weight: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ SS#: _____ Marital Status: _____
Name of Spouse/Parent/Guarantor: _____
Date of Birth: _____ SS#: _____

EMPLOYER

Patient Employed By: _____
Business Address: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____ Business Phone #: _____
Spouse/Parent/Guarantor Employed By: _____
Business Address: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____ Business Phone #: _____

DENTIST/PHYSICIAN

Referred by: _____
Physician: _____
Dentist: _____

INSURANCE (DENTAL)

Insurance Company Name: _____
ID#: _____ Group #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Subscriber Name: _____

INSURANCE (MEDICAL)

Insurance Company Name: _____
ID#: _____ Group #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Subscriber Name: _____



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Patient Information and Medical History (continued)

Are you allergic to penicillin, codeine or any other medicine or drugs? If yes, what?	Yes	No
Are you taking any medicine or drugs? If yes, what?	Yes	No
Have you taken any medicine or drugs during the past year? If yes, what?	Yes	No
Have you been under the care of a physician during the past year?	Yes	No
Have you ever had a major operation?	Yes	No
Have you ever had problems during or after an operation, anesthetic or tooth extraction?	Yes	No
(Female) Are you pregnant?	Yes	No
Are you wearing contact lenses?	Yes	No
Do you have a cough or cold?	Yes	No
Did someone come with you to drive you home?	Yes	No
Have you had anything to eat or drink within the last six hours?	Yes	No
Does your dental or medical insurance cover this procedure? If yes, please complete and submit this form.	Yes	No

Check (✓) any of the following which you have had:

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune Disorders |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Psychiatric Treatment | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Breathing Problem | |

Have you had any other serious illness? Yes ___ No ___ If yes, what? _____

The above information is accurate to the best of my knowledge. I fully accept financial responsibility for all charges incurred.

If you expect to have conscious sedation, you must not eat or drink anything (including water) for at least six hours before your appointment. Prescription drugs however, should be taken with a small swallow of water. You must arrange for a driver/escort who can remain in the office and drive you home. You may not operate a motor vehicle for the rest of the day.

Nitrous Oxide requires only that you do not eat or drink 4 hours prior to treatment. You will be able to drive and function after the procedure is complete.

Please wear comfortable clothing with loose-fitting or short sleeves.

Any patient under 18 year of age, must be accompanied by a parent or legal guardian.

Please call the office prior to your appointment if you are taking any blood thinners (such as Coumadin).

By signing this form, you are attesting that the information is correct to the best of your knowledge and that you will accept financial responsibility for the charges incurred.

Signature _____ Date _____