Timothy R. Gray, DDS

13106 SE 240th, Suite 102 Kent, WA 98031-9211
TEL 253.854.9890

Patient Name _____ MI ___
Preferred Name _____
☐ Male ☐ Female Marital Status: S M W
Date of Birth_____
Social Security _____
Address_____
City_____ State_____ Zip _____

E-Mail Address_____
Home Phone _____
Cell Phone _____
If Minor, Responsible Party _____
Student: Yes No School _____
Referred By _____

IN CASE OF AN EMERGENCY NOTIFY

Name (other than spouse)_____
Telephone_____

Relationship _____
City, State _____

Patient/Parent Employer_____
_____
Occupation _____
Telephone_____

Spouse's Name _____
Spouse's Employer_____
Occupation _____
Telephone _____

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S INFORMATION

Name (Policy Holder) _____
SSN _____
Date of Birth _____
Employer _____
Insurance Company _____
Address _____
City, State, Zip _____
Telephone _____
Group _____
Patient's Relationship to Insured: _____
☐ Self ☐ Spouse ☐ Child ☐ Other_____

SECONDARY SUBSCRIBER'S INFORMATION

Name (Policy Holder)_____
SSN _____
Date of Birth _____
Employer _____
Insurance Company _____
Address _____
City, State, Zip_____
Telephone _____
Group_____
Patient's Relationship to Insured:_____
☐ Self ☐ Spouse ☐ Child ☐ Other _____

AUTHORIZATION

I authorize Timothy R. Gray, DDS, to release any and all medical or dental information for evaluation treatment, and any anticipated care. I also authorize the release of this information to my insurance carrier(s) for the purposes of claims administration, evaluation, utilization review and financial audit. This authorization remains valid and effective from the signature date until revoked in writing. I hereby authorize payment to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges submitted. ***I understand that I am financially responsible for any and all charges (including collection fees); and that I am responsible for knowledge of my insurance program and its limitations***. This office is not responsible for knowing my insurance benefits and limitations. Interest accrues 60 days after services are rendered. I understand that I may request a copy of this form. I have read this authorization and understand its contents.

Please keep in mind, to avoid a cancellation fee,
We do require 2 business days' notice for scheduling changes.

Signed_____ Date _____

PATIENT NAME _____

Please indicate by checking "yes" or "no" if any of the following pertain to your health and medical history. Treatment will not be denied based on a positive response to any of the questions. Treatment may be denied if conditions are not indicated. The success of therapy and our avoidance of complications (infections, drug reactions, toxicity, etc) could be enhanced by answering these questions thoroughly.

YES	NO		YES	NO		YES	NO	
☐	☐	Hospitalization for illness or surgery_____ Date and reason _____ _____ _____	☐	☐	Chest pains on mild exertion	☐	☐	High blood pressure
			☐	☐	Heart trouble	☐	☐	Low blood pressure
			☐	☐	Heart murmur	☐	☐	Excessively swollen ankles
			☐	☐	History of Fen-phen use	☐	☐	Stroke
☐	☐	Reaction or allergy to:	☐	☐	Artificial joints/pins or plates	☐	☐	Arthritis
		☐ Sulfa				☐	☐	Osteoporosis
		☐ Penicillin	☐	☐	Anemia or blood disorders	☐	☐	Hives, skin rash, hay fever
		☐ Erythromycin	☐	☐	Prolonged bleeding	☐	☐	Asthma
		☐ Tetracycline	☐	☐	Kidney disease	☐	☐	Tumor or abnormal growth
		☐ Codeine	☐	☐	Thyroid/parathyroid disorder	☐	☐	Chemotherapy/Radiation
		☐ Dental anesthetic				☐	☐	Epilepsy
		☐ Any other medication	☐	☐	Stomach or duodenal ulcer	☐	☐	Glaucoma
		☐ Latex	☐	☐	Liver disease	☐	☐	Contact lenses
		☐ Foods/pollens/environmental	☐	☐	Tuberculosis	☐	☐	Multiple sclerosis
		☐ Metal	☐	☐	Emphysema	☐	☐	Hard of Hearing L R
☐	☐	Hepatitis	☐	☐	Diabetes			FEMALE
☐	☐	Jaundice	☐	☐	Hypoglycemia			☐ Pregnant
☐	☐	Sexually transmitted Disease(s)	☐	☐	High cholesterol	☐	☐	Other_____ _____
☐	☐	HIV/AIDS						

Are you presently being treated for any illness? Yes No
If yes, please describe _____

HAS A DOCTOR EVER PRESCRIBED AN ANTIBOTIC SPECIFICALLY FOR YOU TO TAKE BEFORE A DENTAL APPOINTMENT? YES NO

Prescription Medications:

1._____ for _____
2._____ for _____
3._____ for _____
4._____ for _____
5._____ for _____

Over-the-Counter Medications

1._____ for _____
2._____ for _____
3._____ for _____
4._____ for _____

Do you take aspirin on a daily basis?	Yes	No
Is it a doctor's recommendation?	Yes	No
Aware of any change in your general health?	Yes	No
A Nervous person?	Yes	No
Have you ever used or do you use tobacco?	Yes	No

Packs per day?_____ How Long?_____ Date quit?_____

How often do you drink alcohol? _____		
Do you use recreational drugs?	Yes	No
Subject to frequent headaches?	Yes	No
Urinating more than 6 times/day?	Yes	No
Often thirsty?	Yes	No
Often exhausted or fatigued?	Yes	No

Date of your last physical _____

Physicians name _____ Phone _____

I understand that all of the above information is correct and current to the best of my knowledge.

Signature _____ Date _____

Initials _____ Date _____ Initials _____ Date_____

Initials _____ Date_____ Initials _____ Date_____