Dr. Thomas J. Griffin, DDS, MS

540 New Waverly Place, Suite #110
Cary, NC 27518
(919) 233-0668

Patient Health History Form

Date:____________________ **Patient's Name:**____
(First, Middle, Last)

I prefer to be called (nickname):______________________________ **DOB:**________________ **Gender:** M | F

Responsible Party Name:____ **Gender:** M | F
(First & Last)

Relationship to Patient:_________________ **Spouse's Name:**______________________________________
(First & Last)

Address:____

Cell Phone:______________________________________ **Home Phone:**______________________________

E-Mail Address:_________________________________ **Pt's School/Employer:**________________________

Referral:_______________________ **Other Family Members Treated By Us:**_________________________

General Dentist:____ **Date of Last Visit:**_________________

Orthodontic Complaint & Dental History:____

____

Medical Conditions or Concerns (ADHD, Spectrum Disorder, Osteoporosis, Diabetes, Cancer, etc.):_______________

____

Pregnant or Planning to become Pregnant:____

Medications:____

Allergies (Food, Drug, Material):____

Please list any additional medical, dental, or general questions/concerns that you feel we should be aware of:____

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I understand that my signature verifies that the information provided on this form is current and accurate. It is my responsibility to update Dr. Griffin of any changes in my dental or medical history.

Signature of Guardian/Patient:____ **Date:**__________________

Signature of Doctor:____ **Date:**__________________