GENTLE CARE DENTISTRY

We take great satisfaction in helping you maintain optimal oral health. Our practice is devoted to comprehensive and preventive patient care.

Dr. Thomas J. Frankfurth, D.D.S., F.A.G.D.
10317A Cross Creek Blvd, Tampa, FL 33647
(813) 973-4300 Fax: (813) 991-9260
GentleCareDentistryTampa.com
GCDTampa@gmail.com

Today's Date: _____

ABOUT YOU

Name: _____
Last First MI

I prefer to be called: _____ ☐Male ☐Female

E-Mail Address: _____

Birthdate: _____ Age: ____ SS#: _____

Home Address: _____

_____
City State Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Hm #:: _____ Cell #: _____

Wk #:: _____

Best phone to contact you: ☐Cell ☐Home ☐Work

Please mark one for appointment reminders:
☐ Sign me up to receive e-mail and text messaging confirmations.
☐ Sign me up to receive text message confirmations, but not email.
☐ Sign me up to receive email confirmations, but not text.
☐ I do not wish to be contacted via text or email.

Employer: _____

Occupation: _____

How did you find out about our practice: _____

_____

Other family members seen by us: _____

☐ Previous ☐ Present Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

Name: _____

Phone #: _____ Alternate Phone #: _____

Person responsible for account if other than the patient

Name: _____

Wk #: _____ Relationship: _____

Hm #:: _____ Cell #: _____

Billing Address: _____

Employer _____

DENTAL INSURANCE

Do you have dental insurance? ☐ Yes ☐ No

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone: _____

Group/Policy/Plan #: _____

ID#: _____

Insured's Name: _____ Birthdate: _____

Relationship to patient: _____

Insured's Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship:_____

Phone #: _____ Alternate Phone #: _____

FINANCIAL CONTRACT

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and for paying co-payments and deductibles my insurance does not cover. I understand that Gentle Care Dentistry uses only the most up to date materials and restores teeth with white fillings though my insurance may only give a benefit at the lower silver rate.

I understand that Gentle Care Dentistry accepts no responsibility for my insurance benefits. Gentle Care Dentistry's personnel will do everything that they can to help me get my full insurance benefit, but they will not guarantee what my insurance plan will pay. I agree to reimburse Gentle Care Dentistry the fees of any collection agency, which may be $9.75 and a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, Gentle Care Dentistry incurs in such collection efforts.

_____
Signature Date

(Continued on the Next Page)

Patient Name: _____ **MEDICAL HISTORY**

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #:: _____Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Y ☐ N

For Women:
Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis/Paget's Disease
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

Please list any other drugs/materials that you are allergic to: _____

_____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) or do you grind your teeth? ☐ Yes ☐ No

Have you ever been told that you snore or have sleep apnea? ☐ Y ☐ N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

HIPAA Consent

I have had full opportunity to read and consider the contents of this consent and your Notice of Privacy Practices. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Signature _____**Date** _____

Relationship to patient: _____

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____Date: _____

Doctor's Comments: _____

_____

_____

_____

_____