



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

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Today's Date: _____

ABOUT YOU

Legal Name: _____
Last First MI
Preferred Name: _____ Gender: _____
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?

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

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

Are you allergic to any of the following?

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin | |

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: _____
