Welcome to our office

1 Personal Information

Patient Name: _____

I prefer to be called: _____

Birth date: ____/ ___ / _____ SS#: _____

❑ Minor ❑ Single ❑ Married ❑ Divorced

Male ❑ Female ❑

Home Address:

Street: _____

City/Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May we contact you at work? Y N

When and where is the best time to reach you? _____

_____

E-Mail Address: _____

Who is responsible for this account? _____

_____

Employer: _____

Occupation: _____

Name of Spouse: _____

Spouse's Employer: _____

Spouse's Occupation: _____

Spouse's Work Phone: _____

May he/she be contacted at work? Y N

Parents (if patient is a child): _____

_____

2 Insurance Information

PRIMARY INSURANCE

Male ❑

Female ❑

Insured's Name: _____

Birth date: _____ / ___ / _____ SS#: _____

Employer: _____

Employer Address: _____

_____

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone: _____

Policy#: _____

Group#: _____

SECONDARY INSURANCE

Insured's Name: _____

Birth date: _____ / ___ / _____ SS# _____

Male ❑ Female ❑

Employer: _____

Employer Address: _____

_____

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone: _____

Policy#: _____

Group #: _____

Who may we thank for referring you to us? _____

(OVER)

3 Medical History

Do you have a personal physician? Y N

Their Name_____

Their Phone: _____

The approximate date of your last doctor visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of any physician? Y N

If yes, please explain: _____

Do you smoke or use tobacco in any form? Y N

Are you presently taking any drugs prescribed by a physician or dentist? Y N

If yes, please list: _____

_____

Do you need to be premedicated before dental treatment? Y N

Have you had any serious medical problems in the last 5 years? Y N

If yes, please explain: _____

_____

_____

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

Y N Cancer/Chemotherapy	Y N Severe Headaches
Y N Heart Murmur/Rheumatic Fever	Y N HIV+/AIDS
Y N Heart Surgery/Pacemaker	Y N Shingles
Y N Chronic Hepatitis	Y N Kidney Problems
Y N Psychiatric Problems	Y N Sinus Problems
Y N High Blood Pressure	Y N Fever Blisters
Y N Low Blood Pressure	Y N Anemia
Y N Heart Attack/Stroke/Angina	Y N Diabetes
Y N Epilepsy/Seizures/Fainting Spells	Y N Tuberculosis (TB)
Y N Drug/Alcohol Abuse	Y N Sickle Cell Disease
Y N Hemophilia/Abnormal Bleeding	Y N Osteoporosis

Have you taken any medication for osteoporosis? Y N

Do you have any known sensitivity to metals? Y N

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Aspirin
Y N Erythromycin	Y N Tetracycline
Y N Dental Anesthetics	Y N Codeine

If you are allergic to any other drugs, please list _____

_____

_____

4 Dental History

Why have you come to the dentist today? _____

_____

Approximate date of your last dental visit? _____

Do your gums ever bleed? Y N

Have you had any periodontal (gum) treatment? Y N

Has any member of your family been diagnosed with gum disease? Y N

Do you like your smile? Y N

Would you like your teeth to be whiter? Y N

Have you ever experienced pain in your TMJ (Jaw Joint)? Y N

Do you ever experience popping or clicking noises in your jaw when you chew or open/close your mouth? Y N

Are you apprehensive about dental treatment? Y N

What is most important to you concerning your teeth? _____

_____

_____

Would you like to prevent dentures? Y N

Please tell us anything we can do to make your dental visits more comfortable for you. _____

_____

Please list an Emergency Contact Person **who does not live with you.**

Name: _____ Phone #: _____

Relationship to you? _____

The above information is correct and I will inform the office of any changes. I understand that I am responsible for all costs of treatment and assign insurance benefits to the doctor. I understand that any outstanding balance is subject to finance charges if over 60 days past due. I have reviewed the office's privacy policy to protect health information and I give permission to be contacted concerning upcoming appointments or financial arrangements. In the event I would have a credit, I authorize Gentle Family Dental Care to leave the credit on my account.

X _____

Signature Date