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"Gentle Family Dentistry"

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date_____ Mobile Phone_____ Home Phone_____

Name_____ Soc. Sec.#_____
Last Name First Name Initial

Email_____

Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone_____

Primary Insurance

Person Responsible for Account_____
Last Name First Name Initial

Relationship to Patient_____ Birthdate_____ Soc. Sec.#_____

Address(if different from patient's)_____

City_____ State_____ Zip_____

Patients Responsible Employed by_____ Occupation_____

Business Address_____ Businesss Phone_____

_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

Additional Insurance

Is patient covered by additional **DENTAL** insurance? ☐ Yes ☐ No

Subscriber Name_____ Relationship to Patient_____ Birthdate_____

Address(if different from patient's)_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan_____

Please Complete Both Sides

Dental History

Reason for Today's Visit_____

Former Dentist_____

Address_____

Date of last dental care_____Date of last dental x-rays_____

Check (✔) if you have had problems with any of the following

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Grinding Teeth
- ☐ Food Collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to hot, cold, sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Are you happy with the appearance of your teeth?_____If no, why?_____

Medical History

Physician's Name_____Date of Last Visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes. describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date_____

(Women) Are you pregnant? ☐ Yes ☐No Nursing ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (✔) if you have or have had any of the following

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HighBlood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS
List medications you are currently taking

_____ _____

_____ _____

ALLERGIES
Are you sensitive or allergic to:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

Consent

TREATMENT CONSENT: I hereby authorize any treatment necessary as related to the dental care of the patient whose name appears in this Health History form and grant authority to administer anesthetics, analgesics, and to perform such operations as maybe deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedures, anesthetics and/or drugs to be employed

Authorization

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT: I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. If I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5% on the unpaid balance will be assessed each month. In case of default on payment of this account, I agree to pay all collections costs, including reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Signature_____Date_____