# Welcome to Gentle DENTAL CARE

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate the better we can care for you.

**Chart #**
OFFICE USE ONLY

## Patient Information

Name
LAST FIRST MI

Date Birth Date

SSN# – – Email

◯ Male ◯ Female ◯ Married ◯ Single ◯ Child

Phone (Home) Phone (Cell)

Phone (Work) Emergency

Address
STREET

CITY STATE ZIP

Contact Preference ◯ Phone ◯ Email ◯ Text

## Dental History

Other family members seen by us?

Current/Past Dentist?

What qualities do you look for in choosing a dentist?

What do you like most and least at other dental offices?

Why did you leave your last dental office?

If you could change anything about your smile, what would it be?

Reason for today's visit?

Describe your current health.

◯ Yes ◯ No Are you currently in pain?

If YES, describe.

◯ Yes ◯ No Do you ever have pain in your jaw joint?

◯ Yes ◯ No Do your gums ever bleed?

◯ Yes ◯ No Do you floss? How often?

◯ Yes ◯ No Do you brush? How often?

Type of bristles? ◯ Hard ◯ Med ◯ Soft

◯ Yes ◯ No Any problems with past dental work?

If YES, describe.

## Medical History

◯ Yes ◯ No Do you have a personal physician?

Dr's Name

Phone Date last visited

◯ Yes ◯ No Are you in good health?

If NO, why?

◯ Yes ◯ No Are you now under the care of a physician?

If YES, why?

◯ Yes ◯ No Are you taking any over-the-counter/prescription drugs?

If YES, list.

### Do you have or ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| ◯ Yes | ◯ No | AIDS/HIV | ◯ Yes | ◯ No | **Heart Murmur** |
| ◯ Yes | ◯ No | Artificial Joints | ◯ Yes | ◯ No | Heart Surgery/Pacemaker |
| ◯ Yes | ◯ No | Artificial Heart Valves | ◯ Yes | ◯ No | Mitral Valve Prolapse |
| ◯ Yes | ◯ No | Anemia | ◯ Yes | ◯ No | Rheumatic Fever |
| ◯ Yes | ◯ No | Arthritis/Rheumatism | ◯ Yes | ◯ No | Hemophilia/Ab. Bleeding |
| ◯ Yes | ◯ No | Asthma | ◯ Yes | ◯ No | Hepatitis-Type _____ |
| ◯ Yes | ◯ No | Allergies | ◯ Yes | ◯ No | Liver Disease |
| ◯ Yes | ◯ No | High Blood Pressure | ◯ Yes | ◯ No | Kidney Problems |
| ◯ Yes | ◯ No | Low Blood Pressure | ◯ Yes | ◯ No | Severe/Frequent Headaches |
| ◯ Yes | ◯ No | Blood Transfusion | ◯ Yes | ◯ No | Shingles |
| ◯ Yes | ◯ No | Cancer/Chemo/Radiation | ◯ Yes | ◯ No | Sinus Problems |
| ◯ Yes | ◯ No | Diabetes | ◯ Yes | ◯ No | Shortness of Breath |
| ◯ Yes | ◯ No | Drug/Alcohol Abuse | ◯ Yes | ◯ No | Smoke or Chew Tobacco |
| ◯ Yes | ◯ No | Emotional/Phychiatric Probs. | ◯ Yes | ◯ No | Tuberculosis |
| ◯ Yes | ◯ No | Emphysema | ◯ Yes | ◯ No | Ulcers/Colitis |
| ◯ Yes | ◯ No | Epilepsy/Siezures | ◯ Yes | ◯ No | Venerial Disease |
| ◯ Yes | ◯ No | Fainting Spells | ◯ Yes | ◯ No | Hospitalized for any reason? Please List. |
| ◯ Yes | ◯ No | Fever Blisters/Canker Sores | | | |
| ◯ Yes | ◯ No | Glaucoma | | | |
| ◯ Yes | ◯ No | Heart Problems | ◯ Yes | ◯ No | Any other medical condition? Please List. |
| ◯ Yes | ◯ No | Congenital Heart Defect | | | |
| ◯ Yes | ◯ No | Heart Attack/Stroke | | | |

If you answered YES to any question above, please explain.

### Are you allergic to any the following?

| | | | | | |
|---|---|---|---|---|---|
| ◯ Yes | ◯ No | Aspirin | ◯ Yes | ◯ No | Latex Gloves |
| ◯ Yes | ◯ No | Barbiturates (Sleep. Pills.) | ◯ Yes | ◯ No | Penicillin |
| ◯ Yes | ◯ No | Codeine | ◯ Yes | ◯ No | Sulfa Drugs |
| ◯ Yes | ◯ No | Dental Anesthetics | ◯ Yes | ◯ No | Any other Allergies? If YES, please list. |
| ◯ Yes | ◯ No | Erythromycin | | | |

### Women Only.

◯ Yes ◯ No Do you take birth control pills?

◯ Yes ◯ No Are you pregnant? If YES, due date?

◯ Yes ◯ No Are you nursing?

## Insurance Information

### Primary

Is Insured a patient? ◯ Yes ◯ No

Insured's Name
LAST FIRST MI

Insured's Birth Date

ID#

Group #

Insured's Address
STREET

CITY STATE ZIP

Insured's Employer Name

Employer Address
STREET

CITY STATE ZIP

Patient's relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name

Insurance Plan Address
STREET

CITY STATE ZIP ( ) - PHONE

### Secondary

Is Insured a patient? ◯ Yes ◯ No

Insured's Name
LAST FIRST MI

Insured's Birth Date

ID#

Group #

Insured's Address
STREET

CITY STATE ZIP

Insured's Employer Name

Employer Address
STREET

CITY STATE ZIP

Patient's relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name

Insurance Plan Address
STREET

CITY STATE ZIP ( ) - PHONE

## Referral Information

Whom may we thank for referring you to our practice?

◯ Another Patient ◯ Yellow Pages ◯ Dental Office
◯ Other

Name of person referring?

Office Notes

## Employment Information

The following is for ◯ the patient
◯ the person responsible for payment

Employer Name Phone

Address
STREET

CITY STATE ZIP

Occupation

## Spouse or Responsible Party Information

The following is for ◯ the patient's spouse
◯ the person responsible for payment

Name
LAST FIRST MI

Date Birthdate

SSN# – – ◯ Male ◯ Female
◯ Married ◯ Single ◯ Child

Phone (Home)

Phone (Work) Best Time To Call

Address
STREET

CITY STATE ZIP

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time the services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In accordance with the Federal Truth-in-Lending Act, any balance older than 60 days will be subject to a billing charge of 5$ per month or finance charges of 21% APR, whichever is greater..

I understand that the fee estimate listed for this dental care can only be extended for a period of one month from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**I have read the above conditions of treatment and payment and agree to their content.**

X
Signature of patient, parent of guardian Date

Relationship to Patient

X
Signature of guarantor of payment/responsible party Date

Relationship to Patient