Welcome

Gentle Dental Care
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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.

1. About You

Today's Date:________________________

Name: ____

I prefer to be called:________________________ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:____Social Security #: ____________

Home Address: ____

City, State, Zip: ____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: ______________________ Pager/Cell#:_________________

WK#: _____________________ Ext._________DL#:______________

Employer: ____

Employer's Address: _____________________________________

How long there?__________ Occupation:_____________________

Where & when are the best times to reach you? _________________

Who may we Thank for referring you? _________________________

Other family members seen by us: ___________________________

Previous/Present Dentist: _________________________________

Last Visit Date:____

2. Spouse Information

Their Name:____

Employer:____

WK#: _______________________ Ext.______SS#:_______________

Birthdate: _______________________ DL#:____________________

Person Responsible for Account: ___________________________

WK#: __________________ Ext.______ HM#:__________________

Billing Address: ____

Relationship: ____________________ SS#:____________________

Employer:_______________________ DL#:____________________

3. Dental Insurance

Primary Dental Insurance

Insurance Co. Name:______________________________________

Insurance Co. Address: ____________________________________

Insurance Co. Phone #:____________________________________

Group # (Plan Local or Policy #): ____________________________

Insured's Name:_______________________Relation:_____________

Insured's Birthday:_________________ Insured's SS#:____________

Insured's Employer:_______________________________________

Secondary Dental Insurance

Insurance Co. Name:______________________________________

Insurance Co. Address: ____________________________________

Insurance Co. Phone #:____________________________________

Group # (Plan Local or Policy #): ____________________________

Insured's Name:_______________________Relation:_____________

Insured's Birthday:_________________ Insured's SS#:____________

Insured's Employer:_______________________________________

In the event of an emergency, is their someone
who lives near you that we should contact?

Their Name:______________________Relation:_________________

WK#: _______________________________HM#:________________

4. Medical History

Do you have a personal physician? ❑ No ❑ Yes

Physician's Name:____

Phone#: _______________________Date of last visit:_____________

CONTINUED ON BACK OF FORM

4. Medical History continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Please Explain: ____

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

Please list each one ____

For Women Are you taking birth control pills? ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes Week # ____________________

Are you nursing? ❑ No ❑ Yes

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

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Congenital Heart Defect	Y	N	Epilepsy/Seizures/Fainting Spells
Y	N	Heart Surgery	Y	N	Diabetes
Y	N	Mitral Valve Prolapse	Y	N	Drub/Alcohol Abuse
Y	N	Heart Murmur	Y	N	Venereal Disease
Y	N	Rheumatic Fever	Y	N	Hemophilia/Abnormal Bleeding
Y	N	HIV+/AIDS	Y	N	Ulcers/Colitis
Y	N	Kidney Problems	Y	N	Cancer/Chemotherapy
Y	N	Artificial Bones/Joints	Y	N	Radiation Treatment
Y	N	Artificial Valves	Y	N	Asthma
Y	N	Sinus Problems	Y	N	Arthritis
Y	N	High Blood Pressure	Y	N	Difficulty Breathing
Y	N	Low Blood Pressure	Y	N	Hospitalized for any reason
Y	N	Severe/Freq. Headaches	Y	N	Hepatitis/Liver Problems
Y	N	Glaucoma	Y	N	Blood Transfusion

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

____

____

____

____

Do you use chewing tobacco? Y N Currently____ How Long____

Have you ever smoked? Y N Currently_____ How Long_____ Packs a Day_____

Are you allergic to any of the following drugs?

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

Please list any other drugs that you are allergic to: _______________

____

5. Dental History

Why have you come to the dentist today? ____________________

____

____

Are you currently in pain? ❑ No ❑ Yes

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ No ❑ Yes

Do you now or have you ever experienced pain/discomfort in you jaw joint (TMJ/TMD)? ❑ No ❑ Yes

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like the appearance of you smile? ❑ No ❑ Yes

If you could change anything about it, what would you change?

____

Do your gums ever bleed? ❑ No ❑ Yes

How many times a day do you brush?_____ a week do you floss?____

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. *I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.*

____

Signature Date

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

Thank you for filling out this form completely.
It will enable us to help you more effectively. If you have any questions at any time, please ask us.
We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I authorize the dental staff to perform the dental services for me where appropriate, including, but not limited to; full mouth exam radiographs, (x-rays), cleaning, fluoride treatment and sealants on molars.

____ ____________________

Patient Signature and/or Parent/Guardian when Patient is a minor Date

How did you hear about our office?

________ Insurance Plan/Provider

________ Welcome Wagon

________ Yellow Pages

________ Friend Referral______________________

________ Other Doctor

________ Other______________________________