We would like to know you better here at Gentle Touch Dental!

Name: _____ DOB: _____ Phone: _____ Male/Female

Email: _____

Address: _____ Zip Code: _____

SSN: _____ Emergency Contact name/phone: _____

Occupation: _____ Employer: _____ Employer phone: _____

Spouse's Name: _____ Spouse's phone: _____ Spouse's DOB: _____

Spouse's Employer: _____ Spouse's Employer phone: _____

Who referred you to our office? _____

When was your last dental appointment? _____

Dental Insurance:

Insurance subscriber Name: _____ DOB: _____

Carrier: _____ ID/SSN: _____ Group # _____

Second Ins: _____ ID/SSN: _____ Group # _____

Acknowledgment of notice of Privacy Practices:

I _____ (print name) have read a copy of this office's Notice of Privacy Practices. (Laminated copy on clip board).

Financial Policy:
Method of payment: Cash/Check/Credit Card/ Care Credit

Payment is expected at time of service. We do accept insurance assignment, but the patient portion is always due at each visit. Ultimately you are responsible for payment of all fees for dental care rendered by our office. We will provide an estimated treatment plan for you and go over any questions you may have. However, these are estimates only. Treatment prices may change during procedure due to unexpected circumstances. We are not responsible for what your insurance may or may not cover. The insurance estimate is not a guaranteed payment.

Print name: _____ Signature: _____

Guardian/POA signature: _____ Date: _____

Medical History: To the best of your knowledge, are you or have you ever been afflicted with:

Heart Ailment	yes/no	Diabetes	yes/no	Hypo/Hyper Thyroid	yes/no
Heart valve replacement	yes/no	Epilepsy	yes/no	Rheumatic fever	yes/no
Hepatitis	yes/no	High blood pressure	yes/no	HIV Positive	yes/no
Respiratory disease	yes/no	Chemo/Radiation	yes/no	Prolonged bleeding	yes/no
Are you pregnant?	yes/no	Healing complications	yes/no	Sleep apnea/CPAP	yes/no
Acid reflux/Gerd/Heartburn	yes/no	Cancer	yes/no		

Over

Do you have any other health concerns not listed? _____

Do you use any tobacco products? Yes/No What kind? _____
Do you have any dental anxiety/fear? Yes/No Specify: _____
Have you had any surgery? Yes/No Specify: _____

Do you have any joint replacements? Yes/No If yes is a pre-medication required? Yes/No

Do you have an allergy to any drug? Yes/No Specify: _____
What Pharmacy do you prefer for prescriptions? _____
Are you currently under a physician's care? Yes/No

Please list your medications:

_____

_____

_____

Dental History:

What is your present dental problem?
Are your teeth sensitive to Hot/Cold/Sweets/Biting? Where: _____
Does food catch between your teeth? Yes/No
Do your gums bleed while brushing? Yes/No
Do you have an unpleasant taste or odor in your mouth? Yes/No
What type of toothbrush do you use? Manual/Electric Hard/Med/Soft
What type of toothpaste do you use? Plain/Sensitive/Whitening/No Fluoride
Problems with Jaw? Clicking/Pain/Difficulty opening/closing/Chewing
Have you ever had a reaction to anesthetic? Yes/No
Are you dissatisfied with your teeth or smile? Yes/No Why? _____

Date Last updated: _____ Signature: _____