PATIENT REGISTRATION

How did you hear about our office? _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Birth Date: _____ Sex: ○ Female ○ Male

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #:_____-_____-_____ Driver's License #:_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐ I would like to receive TEXT correspondences

E-mail:_____ ☐ I would like to receive EMAIL correspondences

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Retired ☐Unemployed

Student Status: ☐Full Time ☐Part Time School Name: _____

Preferred Dentist: _____ Preferred Hygienist: _____ Preferred Pharmacy: _____

Emergency Contact Name: _____ Relationship to Patient: _____ Phone #:_____

☐ I am the patient and the person responsible for payment.

Responsible Party **(Person responsible for payment - If someone other than patient)**

First Name: _____ Last Name: _____ Middle Initial: _____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other: _____ Birth Date: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #:_____-_____-_____ Driver's License #:_____

☐ Responsible Party is Policy Holder for Patient ☐ Primary Policy Holder ☐ Secondary Policy Holder

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Retired ☐Unemployed

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____-_____-_____ Insured Birth Date: _____

Employer Name: _____ Insurance Company Name: _____

Employer Address: _____ Insurance Co. Address: _____

City, State, Zip:_____ City, State, Zip:_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ DATE: _____

Signature of patient (or parent/guardian if minor)

REVISED: APRIL 2016

GENTLE DENTAL CARE MEDICAL HISTORY FORM

How did you hear about us?	☐	If yes
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you smoke or use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes
Alcohol abuse?	○ Yes ○ No	If yes
Are you taking any medications?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Novocaine

Other Allergies? ☐ If yes

Have you had any of the following?

AIDS/HIV Positive	○ Yes ○ No	Hemophilia	○ Yes ○ No
Radiation Treatments	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No
Diabetes	○ Yes ○ No	Hepatitis	○ Yes ○ No
Renal Dialysis	○ Yes ○ No	Emphysema	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No
Epilepsy or Seizures/Convulsions	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Hives or Rash	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Asthma	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Leukemia	○ Yes ○ No	Liver Disease	○ Yes ○ No
Stroke	○ Yes ○ No	Cancer	○ Yes ○ No
Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

REVISED: APRIL 2016