PATIENT REGISTRATION

How did you hear about o	our office?			
Patient Information				
First Name:	Last Name:	Middle Initial:		
Preferred Name:	Birth Date:	Sex: O Female O Male		
Address:		·		
City, State, Zip:				
		Cell Phone:		
Social Security #:	Driver's License #:			
Marital Status: □Married □	lSingle □Divorced □Separated □Widov	wed \Box I would like to receive TEXT correspondences		
E-mail:		I would like to receive EMAIL correspondences		
Employment Status: □Full Time	me □Part Time □Self Employed □Retired	d □Unemployed		
Student Status: □Full Time	□Part Time School Name:			
Preferred Dentist:	Preferred Hygienist:	Preferred Pharmacy:		
Emergency Contact Name:	Relationship to Patient: _	Phone #:		
	\Box I am the patient and the person re	esponsible for payment.		
Responsible Party (Perso	on responsible for payment - If someone other	er than patient)		
First Name:	Last Name:	Middle Initial:		
Relationship to Patient: □Self	□Spouse □Child □Other:	Birth Date:		
Address:				
City, State, Zip:				
		Cell Phone:		
Social Security #:	Driver's License #:			
\square Responsible Party is Policy	Holder for Patient ☐ Primary Policy Ho	lder		
Employment Status: □Full Tir	me □Part Time □Self Employed □Retired	d □Unemployed		
Primary Dental Insurar	nce Information			
Name of Insured:	Relationship t	to Insured: □Self □Spouse □Child □ Other		
Employer ID:	Carrier ID:	Carrier ID:		
Insured Social Security #:	Insured Birth	Insured Birth Date:		
Employer Name:	Insurance Cor	Insurance Company Name:		
Employer Address:	Insurance Co.	Insurance Co. Address:		
ty, State, Zip: City, State, Zip:		p:		
Authorization and Rele	ase_			
answered. I understand that proincluding the diagnosis and the third party payors and/or health my dental insurance may pay le my dependents.	oviding incorrect information can be dangerous trecords of any treatment or examination rendered hyperstrians. I authorize and request my insurses than the actual bill for services. I agree to be r	y knowledge. The above questions have been accurately to my health. I authorize the dentist to release any information to me or my child during the period of such dental care to rance company to pay directly to the dentist. I understand the responsible for payment of all services rendered on my behalt		
X	rent/guardian if minor)			

REVISED: APRIL 2016

GENTLE DENTAL CARE MEDICAL HISTORY FORM

How did you hear about us? Are you under a physician's care now? Have you ever been hospitalized or had a major of the you ever taken Fosamax, Bonka, Actonel or strate you ever taken Fosamax, Bonka, Actonel or strate you ever taken Fosamax, Bonka, Actonel or stray other medications containing bisphosphonetes? Do you smoke or use tobacco? Do you use controlled substances? Or yes on the strate of the s				
times put ever been hospitalized or had a major operation? Heve you sever taken Fosemex, Bonive, Actored or any other medications containing bisphosphonetes? Do you smoke or use tobacco? Do you use controlled substances? Or yes No If yes	How did you hear about us?		If yes	
operation? Have you ver taken Fosamax, Bonivo, Actonel or any other medications containing bisphosphonates? Do you suse controlled substances? Do you suse controlled substances? Oves No If ves Alcohol abuse? Are you taking any medications? Oves No If ves Are you taking any medications? Oves No If ves Are you taking any medications? Oves No If ves Oves No If ves Are you taking any medications? Oves No If ves Over Allergies? If ves Over No Allergies Novocaine Over No Allergies Novocaine Over Novocaine If ves Over Novocaine Over Novocaine Over Novocaine If ves Over Novocaine Over Novocaine If ves Over Novocaine Over Novocaine Over Novocaine If ves Over Novocaine Over Novocaine Over Novocaine If ves Novocaine If ve	Are you under a physician's care now?	© '	Yes ⊚ No If yes	
invery out ever taken Fossmax, Boniva, Actonel or my other medications containing bisphosphonates? In you smoke or use tobacco? In you use controlled substances? In you use to you taking any medications? In you use you taking any medications? In you we you had any of the following? In you you were had any of the following? In you you were had any of the following? In you you were had any serious illness not his form have been accurately answered. I understand that providing incorrect inform deangerous to my (or patent's) health. It is my responsibility to inform the dental office of any changes in medical status.		a major	Yes No If yes	
Taking oral contraceptives? If yes No	Iave you ever taken Fosamax, Boniva, :		Yes No If yes	
looked subser				
re you taking any medications? Ves No If yes men: Are you Pregnant/Trying to get pregnant? vou allergic to any of the following? Aspirin Penicillin Codeine Acrylic		(C)	Yes No	
re you taking any medications? Yes No If yes read any of the following? Acrylic Codeline Acrylic Acrylic	o you use controlled substances?		Yes 🗇 No If yes	
pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?	Icohol abuse?	© ,	Yes ⊚ No If yes	
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?	re you taking any medications?	(in)	Yes No If yes	
Pregnant/Trying to get pregnant? Authority Pregnant/Trying to get pregnant? Nursing? Appirin				
e you allergic to any of the following? Aspirin	omen: Are you			
Aspirin Penicillin Codeine Acrylic Novocaine Metal Sulfa Drugs Novocaine Novocaine Sulfa Drugs Novocaine Sulfa Drugs Novocaine Sulfa Drugs Novocaine Sulfa Drugs Sulfa	Pregnant/Trying to get pregnant?	Nursing?		☐ Taking oral contraceptives?
Metal Latex Sulfa Drugs Novocaine Dither Allergies? If yes AIDS/HIV Positive	e you allergic to any of the following?			
ave you had any of the following? AIDS/HIV Positive ADS/HIV Positive ADS/HIV Positive AVES NO Alzheimer's Disease Yes NO Hepatitis Yes NO Hepatitis Yes NO Hepatitis Yes NO Arthritis/Gout Yes NO Arthritis/Gout Yes NO Arthritis/Gout Yes NO Emphysema Yes NO Arthritical Heart Valve Yes NO Artificial Joint Yes NO Kidney Problems Yes NO Stroke Yes NO Stroke Yes NO Cancer Yes NO Stroke Yes NO Cancer Yes NO Chemotherapy Yes NO Chemotherapy Yes NO Chemotherapy Yes NO Cold Sores/Fever Blisters Yes NO Cold Sores/Fever Blisters Yes NO Heart Trouble/Disease Yes NO Heart Pacemaker Yes NO Balve No Fives NO Heart Pacemaker Yes NO Heart Pacemaker Ye			Codeine	
ave you had any of the following? AIDS/HIV Positive	■ Metal ■ La	tex	Sulfa Drugs	Novocaine
AUDS/HIV Positive	ther Allergies?		If ves	
Radiation Treatments	ave you had any of the following?			
Diabetes Pes No Hepatitis Pes No Emphysema Pessure Pessure Pessures/Convulsions Pess No Arthritis/Gout Pessures/Convulsions Pes No Arthritis/Gout Pessures/Convulsions Pes No Artificial Joint Pess No Blood Transfusion Pess No Blood Transfusion Pess No Liver Disease Pess No Liver Disease Pess No Cancer Pess No Cancer Pess No Chemotherapy Pess No Chemotherapy Pess No Chemotherapy Pess No Heart Attack/Failure Pess No Descoporosis Pess No Heart Attack/Failure Pess No Heart Attack/Failure Pess No Heart Attack/Failure Pess No Heart Trouble/Disease Pess No Heart Pacemaker Pesychiatric Care Pess No Heart Pacemaker Pesychiatric Care Pess No Heart Pacemaker Pess No Heart Pacemak	AIDS/HIV Positive			
Renal Dialysis				
Arthritis/Gout				
Epilepsy or Seizures/Convulsions Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Sinus Trouble Yes No Sinus Trouble Yes No Liver Disease Yes No Liver Disease Yes No Liver Disease Yes No Cancer Yes No Cancer Yes No Cancer Yes No Cancer Yes No Chest Pains Yes No Lung Disease Yes No Chest Pains Yes No Heart Attack/Failure Yes No Diseoporosis Yes No Heart Attack/Failure Yes No Cold Sores/Fever Blisters Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Diseoporosis Yes No If yes No Heart Pacemaker Yes No Diseoporosis Yes No Psychiatric Care Yes No Diseoporosis Yes No Psychiatric Care Yes No Diseoporosis Yes No Psychiatric Care Yes No Diseoporosis Yes No Diseoporosis Yes No Heart Pacemaker Yes No Psychiatric Care Yes No Diseoporosis Yes No	-			
Hives or Rash Asthma Yes No Asthma Yes No Sinus Trouble Yes No Kidney Problems Yes No Blood Transfusion Yes No Leukemia Yes No Liver Disease Yes No Cancer Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Heart Pacemaker Yes No H	_			
Kidney Problems Ves No Blood Transfusion Yes No Leukemia Yes No Liver Disease Yes No Stroke Yes No Cancer Yes No Claucoma Thyroid Disease Yes No Chemotherapy Yes No Chemotherapy Yes No Osteoporosis Yes No Heart Attack/Failure Yes No Cold Sores/Fever Blisters Yes No Heart Trouble/Disease Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Have you ever had any serious illness not listed Yes No Heart Sore Heart So				
Leukemia Yes No Liver Disease Yes No Glaucoma Yes No Cancer Yes No Cancer Yes No Cancer Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Tuberculosis Yes No Heart Attack/Failure Yes No Heart Pacemaker Yes No Heart Prouble/Disease Yes No Psychiatric Care Yes No Mave you ever had any serious illness not listed Yes No If yes Mo If yes M	Asthma	Yes No	Sinus Trouble	
Stroke	Kidney Problems	Yes No	Blood Transfusion	Yes No
Glaucoma Yes No Chemotherapy Yes No Tuberculosis Yes No Fys	Leukemia		Liver Disease	
Thyroid Disease Yes No Chemotherapy Yes No Chest Pains Yes No Heart Attack/Failure Yes No Tuberculosis Yes No Tuberculosis Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Heart Pacemaker Yes No Psychiatric Care Yes No Have you ever had any serious illness not listed Yes No If yes Tuberculosis Yes No Heart Pacemaker Yes No Have you ever had any serious illness not listed Yes No If yes Tuberculosis Yes No Heart Pacemaker Yes No Have you ever had any serious illness not listed Yes No If yes Tuberculosis Yes No Heart Pacemaker Yes No Have you ever had any serious illness not listed Yes No If yes Tuberculosis Yes No Heart Pacemaker Yes				
Chest Pains Osteoporosis Yes No Tuberculosis Yes No Tuberculosis Yes No Heart Attack/Failure Tuberculosis Yes No Heart Pacemaker Psychiatric Care Yes No Heart Pacemaker Psychiatric Care Yes No Heart Pacemaker Yes No Toutherculosis Yes No Heart Pacemaker Psychiatric Care Yes No Toutherculosis Yes No Heart Pacemaker Psychiatric Care Yes No Toutherculosis Yes No Heart Pacemaker Psychiatric Care Yes No Toutherculosis Yes No Heart Pacemaker Psychiatric Care Yes No Toutherculosis No Heart Pacemaker Psychiatric Care Yes No Heart Attack/Failure Tuberculosis No Heart Pacemaker Psychiatric Care Yes No Psychiatric Care Yes No Psychiatric Care Yes No No Heart Pacemaker Psychiatric Care Yes No Psychiatric Care Yes No Heart Pacemaker Psychiatric Care Yes No Psychiatric Care Yes No Heart Attack/Failure Tuberculosis Yes No Heart Pacemaker Psychiatric Care Yes No Psychiatric Care Yes No Heart Pacemaker Psychiatric Care Yes No Heart Pacemaker Psychiatric Care Yes No Heart Attack/Failure Tuberculosis Yes No Heart Pacemaker Psychiatric Care Yes No Heart Attack/Failure Tuberculosis Heart Attack/Failure Tuberculosis Heart Attack/Failure Tuberculosis Heart Attack/Failure Tuberculosis Heart Atta			_	
Osteoporosis Osteoporosis Osteoporosis Oyes No Cold Sores/Fever Blisters Oyes No Heart Trouble/Disease Oyes No Heart Pacemaker Oyes No Fave you ever had any serious illness not listed Oyes No Fave you ever had any serious illness not listed Oyes No Fave you ever had any serious illness not listed Oyes No Fave No Fave Yes No Fave No	•			
Cold Sores/Fever Blisters				
Heart Trouble/Disease	•			
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect inform dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. nature of Patient, Parent or Guardian:			Psychiatric Care	Yes No
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect inforn dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. nature of Patient, Parent or Guardian:	ave you ever had any serious illness n	ot listed 🔘 🖰	l Yes ⊚ No If yes	
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect inforn dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Inature of Patient, Parent or Guardian:	mments.			
dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	·····			
	nature of Patient, Parent or Guardian:			
Date:				Date: