

## WELCOME

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

### PATIENT INFORMATION

Name \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ DOB \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_  
May we call you at work?  Y  N  
Notify in case of emergency \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Business Phone \_\_\_\_\_ Email \_\_\_\_\_  
Whom may we thank for referring you?  Friend or Family, Name \_\_\_\_\_  Our Sign  
 Verizon Yellow Pages  Yellow Pages Big Book  Yellow Pages Small Book, Town \_\_\_\_\_  Peconic Phone Book  
 Our Website  Internet  Insurance Co, Name \_\_\_\_\_  Our Employee, Name \_\_\_\_\_  
 North Shore Today  ET Week  Pennysaver  Other \_\_\_\_\_  
Do you have any family members that come to Gentle Dental? If so, who? \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Business Phone \_\_\_\_\_ Email \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_ Contract # \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber ID \_\_\_\_\_

### ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Phone \_\_\_\_\_ Email \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_ Contract # \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber ID \_\_\_\_\_

## MEDICAL HISTORY

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_  
Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations? Y N  
If yes, please describe \_\_\_\_\_

Are you in good health? Y N Has there been any change in your general health in the past year? Y N  
Are you currently under physician care? Y N If yes, describe \_\_\_\_\_  
Have you ever had a blood transfusion? Y N If yes, give approximate dates \_\_\_\_\_  
Have you ever taken Fen-Phen/Redux? Y N  
Women: Are you pregnant? Y N Nursing Y N Taking Birth Control Pills? Y N

### Are you using any of the following?

Antibiotics? Y N  
Anticoagulants (blood thinners)? Y N  
Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N  
High Blood Pressure medications? Y N  
Steroids (Cortisone, etc.)? Y N  
Weight loss medications (Fen-Phen)? Y N  
Tranquilizers and/or antidepressants? Y N  
Insulin or Oral Anti-Diabetic drugs? Y N  
Digitalis, Inderal, Nitroglycerin or other heart drug? Y N  
Recreational Drugs? Y N  
Are you taking or have you ever taken Bisphosphonates (such as Fosamax or Actonel for osteoporosis, or chemotherapy for multiple Myeloma, etc.)? Y N

Please list any and all medications taken, including prescription and over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_

### Indicate which of the following you have had or have at present:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy or Seizure	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery
<input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting or Dizzy Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Food Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)	Describe _____	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis A B C (circle one)	<input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease/malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit
<input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores/Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N Nervousness/Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease
<input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N Neurological Disorders	
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes		

**Are you allergic to or have you had an adverse reaction to:**

- Local Anesthesia (Novocain, etc)? Y N
- Penicillin or other antibiotics? Y N
- Sedatives, Barbituates? Y N
- Aspirin or Ibuprofen? Y N
- Codeine or other pain killers? Y N
- Latex or Rubber Products? Y N
- Jewelry or Metals? Y N
- Other allergies or reactions? Please list: \_\_\_\_\_

Do you have a history of Alcohol or Chemical Dependency or Emotional Disorder? Y N

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N

**DENTAL HISTORY**

What would you like us to do today? \_\_\_\_\_

Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_ Date of last hygiene visit \_\_\_\_\_

Check (yes (Y) or no (N) if you have had problems with any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting        | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment \_\_\_\_\_

Are you apprehensive about dental work? No Slight Moderate Extreme

Are you interested in Sedation Dentistry? Y N

Are you interested in learning more about?

Invisalign  Teeth Whitening  Implants Cerec One Visit Dentistry Botox and Juvederm

*Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. With whom may we discuss your dental or financial situation? Please list name(s) and relationship.*

I affirm that the information I have given is correct to the best of my knowledge. It 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 insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**Office Use Only**

I have verbally reviewed the medical/dental information above with the parent named herein \_\_\_\_\_

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date