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:

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

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:

☐Y ☐N Bad breath	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal treatment
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot
☐Y ☐N Sensitivity to sweets	☐Y ☐N Sensitivity when biting	☐Y ☐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