Gentle Dental Patient Registration & Dental Health

PATIENT

Date: _____

Patient Name	Social Security Number	Home Phone ☐ ( )	*Please check one box at left to show the preferred way to contact by phone*
Home Address	City, State, Zip	Cell Phone ☐ ( )	
Email Address		Work Phone ☐ ( )	
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	Gender Identity ☐ Male ☐ Female ☐ Other _____ Gender Assigned at Birth ☐ Male ☐ Female	Birth date	Drivers License and State

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

RESPONSIBLE PARTY If same as patient check here ☐

Name	Social Security Number	Home Phone ☐ ( )	*Please check one box at left to show the preferred way to contact by phone*
Home Address	City, State, Zip	Cell Phone ☐ ( )	
Email Address		Work Phone ☐ ( )	
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	☐ Male ☐ Female Preferred Pronoun _____	Birth date	Drivers License and State
Responsible Person's Employer	Occupation		
Employer's Address	City, State, Zip		

SPOUSE

Name	Social Security Number	Birth date	Home Phone ☐ ( )	*Please check one box at left to show the preferred way to contact by phone*
Employer	Occupation		Cell Phone ☐ ( )	
Employer Address	City, State, Zip		Work Phone ☐ ( )	

EMERGENCY CONTACT

Name	Relationship	Phone ( )
Name	Relationship	Phone ( )

If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____ *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____ _____

**Signature* *Date* *Relationship to Patient*

Terms and Conditions: This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

_____ _____

Signed *Date*

Patient Name _____ **Date of Birth** _____

Dental History

A. Why have you come to see us today? (e.g.: pain, checkup/cleaning, etc.) _____

B. Previous Dentist _____ Last Visit _____ Date of last cleaning _____

C. Reasons for changing dentists, if applicable: _____

D. Have you had any problems with past dental treatment? _____

E. Are you nervous or anxious about seeing a dentist? ☐ Yes ☐ No
If yes please, tell us why: _____

F. Have you ever been sedated or had nitrous oxide (laughing gas) for your dental treatment? ☐ Yes ☐ No Please explain:
_____

G. Do you usually take antibiotics prior to dental treatment? ☐ Yes ☐ No Why? _____

H. How often do you brush? _____ Do you floss? ☐ Yes ☐ No How often _____

I. Do you use a power brush, water pik or power flosser? ☐ Yes ☐ No Which one? _____

Oral Health (Please circle Y for yes or N for no where it applies below)

1. I consider my oral health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor If fair or poor, please describe: _____
_____
2. Y N Do you have pain from your teeth or gums? Please describe: _____
_____
3. Y N Have you had a facial or jaw injury? Please describe: _____
4. Y N Do you have problems eating? Please describe: _____
5. Y N Do your gums feel tender or swollen, or do they bleed while brushing or flossing?
6. Y N Have you ever been told that you have gum disease, gingivitis, “pyorrhea”, periodontitis, or periodontal disease?
7. Y N Would you like to improve your smile? Please describe: _____
8. Y N Do you want your teeth whiter?
9. Y N Do you prefer tooth-colored fillings/crowns?
10. Y N Do you want your teeth straighter? Please describe: _____
11. Y N Are you dissatisfied with how your teeth bite together (your “bite”)?
12. Y N Have you had changes to your bite? Describe: _____
13. Y N Would you like to have orthodontics to straighten your teeth or improve your bite?
14. Y N Do you have orthodontics/braces/aligners/retainers now or in the past?
16. Y N Do you clench or grind your teeth during the day or while sleeping?
17. Y N Do you wear a night guard or similar device to protect your teeth?
18. Y N Does your jaw click or pop when you open your mouth?
19. Y N Do you have jaw pain, now or in the past?
20. Y N Have you been told that you have symptoms of “TMJ” disorder or “TMD”?
21. Y N Do you snore when you sleep?
22. Y N Have you been told that you stop breathing in your sleep?
23. Y N Do you suffer from insomnia, have other sleep disturbances, or take a sleep aid?
24. Y N Does your mouth feel dry (or drier than it used to feel) much of the time?
25. What are priorities for your oral health? (e.g.: appearance, dental health, financial considerations, etc.) Please describe:
_____
_____
_____

Gentle Dental Patient Medical History

Patient Name _____ **Date of Birth** _____

General Health

1. I consider my general health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   If fair or poor, please describe: _____

Do you have or have you had any of the following? Please circle Y for yes or N for no.

2. High Risk for Bacterial Endocarditis
   a. Y N Artificial (prosthetic) heart valve**
   b. Y N Previous infective endocarditis (heart infection)**
   c. Y N Damaged valves in transplanted heart **
   d. Congenital heart disease (CHD):
      Y N Unrepaired cyanotic CHD, including shunts and conduits (blood bypassing the lungs) **
      Y N CHD, repaired (completely) in last 6 months**
      Y N CHD, repaired with residual defects**

*** Except for these conditions, antibiotic prophylaxis is no longer recommended for any other form of heart disease or CHD*

3. Cardiovascular Diseases
   a. Y N Heart Disease Please describe: _____
   b. Y N Heart valve problem/Heart Murmur/Mitral Valve Prolapse/Rheumatic fever
   c. Y N Heart arrhythmia
   d. Y N Pacemaker
   e. Y N Abnormal Blood Pressure High or low? _____ Typical blood pressure: _____
   f. Y N Heart attack Date: _____Please describe: _____
   g. Y N Stent or bypass
   h. Y N Stroke Date: _____Please describe: _____
   i. Y N I take aspirin daily Dose: _____
   j . Y N I take blood thinners daily (e.g., Coumadin/warfarin, Eliquis, Pradaxa, Xarelto, Plavix, etc.) Name of medication: _____

4. Respiratory Diseases
   a. Y N Tuberculosis
   b. Y N Lung disease, COPD, pneumonia, bronchitis Please describe: _____
   c. Y N Asthma, reactive airway disease, wheezing, or breathing problems
   d. Y N Sinus trouble/sinus surgery
   e. Y N Hay fever

5. Diabetes/Endocrine Diseases
   a. Y N Diabetes Type _____ My last "A1c" was _____ Date:_____
   b. Y N Take insulin/medications for diabetes If so, please provide name: _____
   c. Y N I measure my blood sugar How often: _____
   d. Y N Excessive urination and/or thirst
   e. Y N Thyroid disease or pituitary disease Please describe: _____

6. Stomach, Liver and Kidney Diseases
   a. Y N Ulcers/GERD (acid reflux)/intestinal problems
   b. Y N I take antacids like Pepcid, Zantac, Prilosec, etc.
   c. Y N Bulimia
   d. Y N Liver disease, jaundice, or hepatitis Type _____
   e. Y N Kidney Disease
   f. Y N Dialysis If so, what days? _____

7. Other Diseases and Conditions
   a. Y N Arthritis, Please indicate type (osteoarthritis, rheumatoid, etc.): _____
   b. Y N Implants/artificial joints: hip, knee _____ Other _____
   c. Y N Trauma – head, neck or body? Please describe: _____
   d. Y N Organ transplant/donor Which organ? _____ When? _____
   e. Y N Cancer, tumor or malignancy Please describe: _____
   f. Y N Chemotherapy/radiation therapy
   g. Y N Anemia, sickle cell disease/trait, or blood disorder
   h. Y N Hemophilia, bruising easily, or excessive bleeding
   i. Y N Herpes/apthous ulcers
   j. Y N Sexually transmitted/venereal diseases
   k. Y N HIV/AIDS
   l. Y N Immune suppressed disorder Please describe: _____
   m. Y N Glaucoma

Doctor Notes Only:

Patient Name _____ **Date of Birth** _____

n. Y N Hearing loss/hearing aids
o. Y N Recurrent or frequent headaches/migraines Please describe: _____
p. Y N Fainting, loss of consciousness or dizziness Please describe: _____
q. Y N Cerebral palsy, brain injury, epilepsy, or convulsions/seizures
r. Y N History of drug addiction or alcohol addiction
s. Y N Behavioral, emotional, communication, or psychiatric problems/treatment Please describe: _____
Treatment received medications: _____
t. Y N Dementia, Alzheimer's disease or other memory disease Please describe: _____
Treatment received medications: _____
u. Y N Have you taken opiates/narcotics to manage pain? Last taken date: _____
v. Y N Do you smoke/vape/use chewing tobacco? If yes, how much per day? _____ How many years? _____
w. Y N Do you consume alcohol? If yes, how much per day? _____ How many years? _____
x. Y N Do you use marijuana? If yes, how much per day? _____ How many years? _____
y. Y N Do you use recreational drugs? If yes, how much per day? _____ How many years? _____
z. Y N Do you take or have you ever taken bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) or other "anti-resorptive" drugs for Osteoporosis or any other condition? If so, do you receive them by IV or take them orally? _____

8. Y N Have you had any major surgeries or hospitalizations?
Year _____ Type of operation _____
Year _____ Type of operation _____
Year _____ Type of operation _____
Year _____ Type of operation _____

9. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

10. Women:
a. Y N Are you taking birth control medication? Which one: _____
b. Y N Are you or could you be pregnant? Due date: _____
c. Y N Are you nursing? Baby's birth date: _____

11. Are you allergic to any of the following?
a. Y N Local Anesthetics (i.e., Novocain, Lidocaine)
b. Y N Penicillin
c. Y N Other antibiotics _____
d. Y N Latex
e. Y N Aspirin (Excedrin, Bayer, etc.)
f. Y N Ibuprofen (Advil, Motrin, etc.)
g. Y N Acetaminophen (Tylenol, etc.)
h. Y N Sulfa Drugs/Sulfites/Sulfides
i. Y N Codeine
j. Y N Metals, Plastics
k. Y N Dyes or artificial coloring
l. Y N Iodine, iodine-based antiseptics, shellfish or radiologic dyes Which one? _____
m. Y N Pine nuts, colophony, peanuts, other nuts? Which one? _____
n. Y N Other Medications. Which ones? _____
o. Y N Other Allergies. Which ones? _____

12. Please list all medications or suppliments you are currently taking (or submit list of medications):
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

13. Physician's Name _____ Phone _____ Fax _____
Address _____ Date last seen by Physician? _____

Initial medical/dental reviewed by:

(If patient is a minor, guardian's signature is required)

X _____ *Doctor's Signature* _____ *Date*
X _____ *Patient's Signature* _____ *Date*

Periodic medical/dental reviewed by:

X _____ *Doctor's Signature* _____ *Date* ☐ *No changes to above* X _____ *Patient's Signature* _____ *Date*
X _____ *Doctor's Signature* _____ *Date* ☐ *No changes to above* X _____ *Patient's Signature* _____ *Date*
X _____ *Doctor's Signature* _____ *Date* ☐ *No changes to above* X _____ *Patient's Signature* _____ *Date*

Doctor Notes Only: