GENTLE DENTISTRY

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial _____

Gender: M / F Date of Birth_____ SSN_____

Driver's License#_____ Married: Y / N

Mailing Address _____ City_____ State_____ ZipCode_____

E-mail _____ Home Phone_____Cell_____

Employer Name_____ Employer Phone_____

Emergency Contact_____ Phone_____

How did you hear about Gentle Dentistry? _____

RESPONSIBLE PARTY

If the patient is under 18 years old, please complete the following:

Last Name_____ First Name_____ Middle Initial _____

Date of Birth_____ Male/Female Married Y / N SSN_____Driver's License_____

E-mail_____ Home Phone _____ Cell _____

INSURANCE POLICY

Patient relationship to subscriber [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID # _____

Insurance Co. _____ Subscriber SSN _____ DOB _____ Phone_____

Employer_____ Group Name_____ Group # _____

FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance and receive payment directly from them. If sent to collections, by signing below I agree to pay all amounts(s) owed within 30 days of when such amounts(s) are incurred. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.50% per month) until paid in full. In the event any amounts(s) is/are referred to a third party debt collection agency, I agree to pay additional interest, court costs and reasonable attorney's fees. I will also be responsible for a collection fee of up to 33.33% of the principal amount(s) owing as allowed by Utah Code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amounts(s) are incurred today or after today. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. Treatment plans may change and I will be responsible for the work actually done. I understand that all fees are payable at the time of treatment. I also understand there is a $25 missed appointment fee for every 30 minutes of the appointment if I don't notify the office within 24 hours of my appointment time.

Signature _____ Date_____

MEDICAL HISTORY **NAME----------**

Name of Medical Doctor _____

City/State_____

List any medications you are now taking:

[ ] None

_____

_____

_____

_____

Check medications you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/Other Narcotics
[ ] Erythromycin
[ ] Latex rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain upon Exertion
[ ] Damaged Heart Valve
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequent Dry Mouth
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis

Are you taking, or have you taken bisphosphonates (e.g. Fosomax) for osteoporosis? Y / N

Tobacco use? Y / N If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Women – Are you pregnant? Y / N Are you taking birth control pills? Y / N

DENTAL HEALTH

Reason for today's visit? _____ Are you in pain? Y / N

Date of last dental visit_____

Do you have wisdom teeth? Y / N Are you missing any teeth? _____

How happy are you with your smile? Not Happy 1 2 3 4 5 6 7 8 9 10 Very Happy

Do your gums bleed? Y / N

By signing below, I certify that all of the above information is true to the best of my knowledge.

Signature_____ Date_____

Gentle Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

(You may refuse to sign the Acknowledgment)

I have received/was offered a copy of this office's Notice of Privacy Practices.

Print name_____

Signature_____

Date_____

I authorize Gentle Dentistry to discuss and/or release my medical information including labs and test results, diagnosis, and treatments discussed to the following individuals. Also, I authorize Gentle Dentistry to discuss my account information including account balances, insurance information, statements, and payment options to the same persons.

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____