



## 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 \_\_\_\_\_ Zip Code \_\_\_\_\_  
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 \_\_\_\_\_