Gentle Dental Care Patient Information

Patient Name: ____**Date of Birth:**________________**Age:**_____
(Last) (First) (M)

Male Female Social Security: ______________________ **Email Address**:_____________________________

Address:__________________________________ **City:**______________________**St:**_______ **Zip:**______________

Phone #'s Home__________________________ **Work** ___________________**Cell**__________________________

Spouse or Parent/Guardians:_________________________________**Phone:**______________________________

Whom may we thank for referring you to our office?____

How did you hear about our office? Newspaper? Web site? Ad? Other?______________________________
(please circle one)

In the event of an emergency – List person who we should contact?

Name: _________________________________**Relationship to Patient:** ________________________________

Home Ph#:__________________________ **Work #:**_____________________ **Cell #:**_____________________________

Responsible Party

Name of person responsible for this account: __________________________**Relationship:** _________________________

Address: ____________________________________**City:** _______________________**St**_________**Zip**_____________

Date of Birth: ____________**Social Security:** ____________________**Employer?** ____________ __________________

Home Ph#:__________________________ **Work #:**______________________ **Cell #:**_____________________________

Insurance Information

Primary Insurance

Insurance Co. Name: ____________________Phone#:_______________________ Group# ___________________

Insured Name: ________________________________Insured's Social Security #:__________________________

Insured's Birthdate: ___________________ Relationship:________ Phone #: ______________________

Insured's Employer:______________________________Address: ____

Secondary Insurance

Insurance Co. Name: ____________________ Phone#:_____________________ Group# _______________________

Insured Name: ________________________________ Insured's Social Security #:________________________________

Insured's Birthdate: _______________________ Relationship:________________ Phone #: _______________________

Insured's Employer:_____________________________ Address: ____

Dental History

Why have you come to the dentist today? _ ____

Previous/Present Dentist: ____________________________________Last visit date: _______________________

Are you currently in pain? Yes No Do you require antibiotics before dental treatment? Yes No

Your current dental health is Good Fair Poor Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft Do your gums ever bleed? Yes Ever itch? Yes No

Have you ever had periodontal disease? Yes No Are your teeth sensitive to heat, cold, or anything else? ___________________

Do you have mobility in your teeth? Yes No Do you still have wisdom teeth? Yes No

Do you brux, grind or clench your teeth? (circle one) Yes No

Are you happy with the way your smile looks? Yes No If not, what would you change?_____________________________________

Medical History

Do you have a personal physician? Yes No

Physician's Name: ______________________________ ___Phone #: ___________________________ Date of last visit: __________________

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No
Please explain: ____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Phen-Fen, Redux or Pondimin? Yes No

For Women: Are you taking birth control pills? Yes No
Are you pregnant? Unsure Yes No

Do you or have you experienced the following?

YN

Y N Abnormal Bleeding	Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alzheimer's	Y N Congenital Heart Defect	Y N Headaches/Migraines	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack/ Surgery	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/ Joints	Y N Drug Abuse	Y N Heart Trouble/ Disease	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis A, B, C	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV +/ AIDS	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical conditions(s) that you have experienced: ____

Are you taking any prescription/ over the counter drug? Yes No If yes, please list each one: ____
____

Are you allergic to any of the following? (please check, if yes)

Dental Anesthetics Penicillin Sulfa Drugs Jewelry/Metals Aspirin
Codeine Erythromycin Latex Sedatives Tetracycline

Please list anything additional that causes allergic reactions:____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____
Signature Date

Gentle Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,________________________________ , have received a copy of this office's Notice of Privacy Practices.

______________________________   ________________________________
{Signature}   {Date}

____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)_____________________________

Gentle Dental Care

Carlee C. Boles, DDS
19190 Stone Oak Parkway, Suite 116
San Antonio, Texas 78258
(210) 402-6002

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance.

We will prepare and file your insurance claim for you, however, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** a party to that contract. Our relationship is with you. We cannot become involved with disputes with you and your insurer regarding deductibles, co-payments, covered charges and "usual and customary" charges.
2. All charges are **YOUR** responsibility whether your insurance company pays or does not pay. We do our best to give you an estimate of your out-of-pocket expense based on the information your insurance company will provide to us.
3. Patient co-payments along with unpaid deductibles are due at the time of treatment. We collect the portion not expected to be paid by the insurance company, send the claim, and wait a maximum of 60 days for reimbursement from the insurance company. After 60 days the patient is responsible for all unpaid balances.

We reserve the right to charge a fee of **$35 per hour** for broken or missed appointments without a 24-hour notice.

________________________________ ________________________________

Signature Date