

Chart #: _____
FOR OFFICE USE ONLY

gentle dental

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name _____ **Date:** _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #
City State Zip Code

Email: _____ **Gender:** Male Female **Family Status:** Single Married Child

Social Security #: _____ **Medicaid ID:** _____ **Birth Date:** _____

Drivers License # _____ ****Office Use only: Copy in file? Yes No**

****HIPPA**:** Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

| | | |
|-------------------------------------|--|---------------------------------|
| Home Phone: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Best time to call: _____ |
| Work Phone: _____ Ext: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Best time to call: _____ |
| Cell Phone: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Best time to call: _____ |
| Cell Text Message: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E-mail: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Pager: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Fax: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Employer: _____ **Occupation:** _____

Employer Address: _____
Street City, State Zip Code Phone

In case of an emergency, contact: _____ Phone _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Only if the person responsible for this account is **NOT** the patient, complete the following information **for the Guarantor:**

Guarantor Name: _____

Relationship to Patient: Self Spouse Child Other _____

Gender: Male Female **Family Status:** Married Single Divorced Child Other _____

Address: _____
Street City State Zip Code

Social Security #: _____ **Birth Date:** _____

Drivers License # _____ ****Office Use only: Copy in file? Yes No**

Phone Numbers: Home: _____ Work: _____ Ext: _____ Pager: _____
Cell: _____ Fax: _____ E-mail: _____

Employer Name: _____ **Occupation:** _____

Employers Address: _____
Street City State Zip Code Phone

REFERRAL INFORMATION

How did you learn about, or who referred you to, our dental office? Patient/friend Our Staff, Another Dental Office,
 Yellow Pages, Insurance Plan, Newspaper, TV, Website, Newsletter, School, Your employer
 Direct Mail Postcard Other _____

Name of person or dental or medical office who referred you: _____

Please indicate your preferred dentist or hygienist in our office: _____

INSURANCE INFORMATION

Primary Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? Yes No

Relationship to Patient: Self Spouse Child Other _____

Insured's Social Security # _____ Birth Date: _____ Date Employed _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Work Phone: _____ Ext _____

Address: _____
Street City State Zip Code

Insurance Carrier/Plan Name: _____ Insurance Group #: _____ Insurance ID#: _____

Insurance Company Address: _____
Street City State Zip Code Phone

Medical Insurance

Name of Primary Subscriber/Insured: _____ Is the insured a patient? Yes No

Relationship to Patient: Self Spouse Child Legal Guardian Other _____

Insured's Social Security # _____ Birth Date: _____ Date Employed _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Work Phone: _____ Ext _____

Address: _____
Street City State Zip Code

Insurance Carrier/Plan Name: _____ Insurance Group #: _____ Insurance ID#: _____

Insurance Company Address: _____
Street City State Zip Code Phone

PATIENT'S HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following health problems, conditions or habits?

- | | | | |
|--|---|---|--|
| <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> AIDS <input type="checkbox"/> <input type="checkbox"/> Allergy (Codeine) <input type="checkbox"/> <input type="checkbox"/> Allergy (Penicillin) <input type="checkbox"/> <input type="checkbox"/> Allergy Other _____ <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> <input type="checkbox"/> Artificial Joints, Pins... <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Back Problems <input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormally <input type="checkbox"/> <input type="checkbox"/> Blood Disease <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> <input type="checkbox"/> Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> <input type="checkbox"/> Cough, Persistent | <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Cough up blood <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Growths <input type="checkbox"/> <input type="checkbox"/> Hay Fever <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Head Injuries <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> <input type="checkbox"/> Hemophilia <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> Hernia Repair <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> Jaw Pain | <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Mental Disorders <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> <input type="checkbox"/> Pacemaker <input type="checkbox"/> <input type="checkbox"/> Pregnancy Due date: _____ <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Rheumatism <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease (including HIV/AIDS) <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> <input type="checkbox"/> Sinus Problems <input type="checkbox"/> <input type="checkbox"/> Skin rash <input type="checkbox"/> <input type="checkbox"/> Smoking ___/day ___/year | <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Stomach Problems <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Swelling of feet/ankles <input type="checkbox"/> <input type="checkbox"/> Substance Abuse <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> Tobacco Habit <input type="checkbox"/> <input type="checkbox"/> Tonsillitis <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Tumors <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> Venereal Disease <input type="checkbox"/> <input type="checkbox"/> Other: |
|--|---|---|--|

Have you ever had any of the following dental problems or conditions? Please check those that apply:

- | | | | |
|---|---|--|--|
| <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Bad Breath <input type="checkbox"/> <input type="checkbox"/> Bad Taste <input type="checkbox"/> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> <input type="checkbox"/> Clicking/popping of jaw <input type="checkbox"/> <input type="checkbox"/> Food caught in teeth | <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Grinding or clenching teeth <input type="checkbox"/> <input type="checkbox"/> Loose teeth <input type="checkbox"/> <input type="checkbox"/> Broken Fillings <input type="checkbox"/> <input type="checkbox"/> Periodontal treatment <input type="checkbox"/> <input type="checkbox"/> Sensitivity to cold | <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to sweets <input type="checkbox"/> <input type="checkbox"/> Sensitivity to hot <input type="checkbox"/> <input type="checkbox"/> Sensitivity when biting <input type="checkbox"/> <input type="checkbox"/> Sores/growth in the mouth <input type="checkbox"/> <input type="checkbox"/> Local Anesthetic-Novocain | <p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Nitrous Oxide <input type="checkbox"/> <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> <input type="checkbox"/> General Anesthetic <input type="checkbox"/> <input type="checkbox"/> Extractions <input type="checkbox"/> <input type="checkbox"/> Braces |
|---|---|--|--|

Please answer the following dental/medical questions:

- Have you ever been, or do you need to be, pre-medicated for dental work? Yes No
- How often do you floss? _____
- How often do you brush? _____



HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: *(Please print)*

| | | |
|-----------|------------|--------|
| LAST NAME | FIRST NAME | MIDDLE |
|-----------|------------|--------|

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes ___ No ___

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

| | | |
|----------------------------|---------|--------|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Dental/Medical Information | Yes ___ | No ___ |

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

| | | |
|----------------------------|---------|--------|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Dental/Medical Information | Yes ___ | No ___ |

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

| | | |
|----------------------------|---------|--------|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Dental/Medical Information | Yes ___ | No ___ |

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

| | | |
|----------------------------|---------|--------|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Dental/Medical Information | Yes ___ | No ___ |

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

| | | |
|----------------------------|---------|--------|
| Appointment Information | Yes ___ | No ___ |
| Billing Information | Yes ___ | No ___ |
| Dental/Medical Information | Yes ___ | No ___ |

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: _____ Name: _____

DATE: _____

SIGNED: _____

WITNESS: _____

Print Name: _____

Print Name: _____

Relationship to Patient: Self ___ Spouse ___ Parent ___ Child ___ Legal Guardian ___ Other: _____