We would like to know you better here at Gentle Touch Dental South!

Name:_____ DOB:_____

Home Phone:_____ Cell Phone:_____ Male / Female

Email:_____

Address:_____ ZIP:_____

SSN: _____ Emergency Contact Name/Phone:_____

Occupation/Employer: _____ Employer Phone:_____

Spouse's Name/DOB:_____ Spouse's Phone:_____

Spouse's Occupation/Employer:_____ Spouse's Employer Phone:_____

How did you hear about Gentle Touch Dental South?_____

When was your last dental appointment?_____

Dental Insurance:
Insurance Subscriber Name:_____ Subscriber DOB: _____

Insurance Company: _____ ID/SSN:_____ Group Number:_____

Secondary Insurance: _____ ID/SSN:_____ Group Number:_____

Notice of Privacy Practices Acknowledgment:

I _____(Print Name) have read a copy of this office's Notice of Privacy Practices. (Laminated copy located on the clipboard)

Financial Policy:
Method of Payment: Cash / Check / Credit Card / Care Credit

Payment is expected at the time of service. We do accept issuance assignments, but the patient portion is always due at time of visit. Ultimately you are responsible for payment of all fees applied for dental care rendered by our office. We will provide an estimated treatment plan for you and answer any questions you may have. However, these are estimates only. Treatment prices may change during the procedure due to unexpected circumstances. We are NOT responsible for insurance coverage amounts/fees. The insurance estimate provided in our office is NOT a guarantee of payment.

Print Name:_____ Signature:_____ Date:_____

Guardian/POA Signature:_____ Date:_____

Medical History— To the best of your knowledge, are you or have you ever been afflicted with:

Heart Ailment	Yes / No	Diabetes	Yes / No	Hypo/Hyper Thyroid	Yes / No
Heart Valve Replacement	Yes / No	Epilepsy	Yes / No	Rheumatic Fever	Yes / No
Hepatitis	Yes / No	High Blood Pressure	Yes / No	HIV Positive	Yes / No
Respiratory Disease	Yes / No	Chemo/Radiation	Yes / No	Prolonged Bleeding	Yes / No
Are you pregnant?	Yes / No	Healing Complications	Yes / No	Sleep Apnea/CPAP	Yes / No
Acid Reflux/Gerd	Yes / No	Cancer	Yes / No	Anxiety	Yes / No
Depression	Yes / No	High Cholesterol	Yes / No		

Do you have any other health concerns not listed?_____

Do you use any tobacco products? Yes / No What kind? _____

Do you have any dental anxiety/fear Yes / No Specify: _____

Have you ever had surgery of any kind? Yes / No Specify: _____

Do you have any joint replacements? Yes / No If 'Yes' is a pre-medication required? Yes / No

Do you have an allergy to any drugs? Yes / No Specify: _____

Pharmacy preferred for prescriptions? _____

Are you currently under a physician's care? Yes / No

Please List Your Medications:

_____

_____

_____

_____

Dental History:

What is your present dental problem?_____

Are your teeth sensitive to Hot/Cold/Sweets/Biting?_____

Does food catch between your teeth? Yes / No

Do your gums bleed while brushing? Yes / No

Do you have an unpleasant taste or odor in your mouth? Yes / No

What type of toothbrush do you use? Manual / Electric Hard / Med / Soft

What type of toothpaste do you use? Plain / Sensitive / Whitening / No Fluoride

Problems with your jaw? Clicking / Pain / Difficulty Opening / Closing / Chewing

Have you ever had a reaction to anesthetic? Yes / No

Are you dissatisfied with your teeth and/or smile? Yes / No Why?_____

Today's Date:_____ Signature:_____