Gentle Dentist

Name: _____Preferred Name:_____Male □ Female □ Date:_____
Street Address:_____City:_____State_____ Zip Code: _____
Home Phone: _____ Cell Phone:_____Date of Birth:_____Age:_____
Social Security Number:_____If Child, Name of Parent or Legal Guardian_____
Occupation:_____ Employer:_____ Employer Phone:_____
Email Address: _____ Spouse's Name: _____
Who may we thank for referring you to our office? _____ Emergency Contact & Phone #_____
_____

For Insurance Purposes:
Do you have Dental Insurance? _____ If yes, name of Dental Insurance:_____
Policy Holder: _____ Patient ID Number: _____ Date of Birth_____
Group Number: _____ Insurance Phone Number:_____
Insurance Address:_____ City:_____ State:_____ZipCode:_____
Employer:_____ Employer Phone Number:_____

How would you like to receive your appointment reminders: Phone Call Email Text

*I authorize release of any necessary information to the insurance company. Signature: _____

*I authorize payment by my Insurance Company to the Doctor providing care. Signature: _____

				Yes	No
When was your last dental appointment?			Do you have any general health problems? If so, please specify.		
Why did you leave your last dental office?			Have you ever had surgery? If so, please specify.		
What is your current dental problem?			Do you smoke cigarettes? If so, how many?		
Are your teeth sensitive to: Heat Cold Sweets Biting Pressure			Are you currently taking any medications? If so, please specify.		
Problems with the jaw or TMJ: Clicking Noise Pain (joint/side of face/ear) Difficult to Open/Close Difficult to Chew			Are you currently under the care of a doctor? Reason: Doctor's name:		
	Yes	No	High Blood Pressure		
Does food catch between your teeth?			Diabetes		
Do your gums ever bleed?			Rheumatic Fever		
Do you have any gum swelling?			Epilepsy		
Do you have an unpleasant taste or odor in your mouth?			HIV or Hepatitis Positive		
Have you ever had a reaction to local anesthetic?			Respiratory Disease		
Are you dissatisfied with your teeth and their appearance?			Are you pregnant or nursing?		
Have you ever had any teeth removed? How long ago?			Heart Ailment If so, please specify.		
Do you think you will eventually wear dentures?					
Has previous dental work broken or needed repair often?			Prolonged Bleeding or Healing Complications If so, please specify.		
Are finances a concern regarding dental work?			Allergies to medications, latex, anesthetic, etc. If so, please specify.		
Are you afraid of having dental work? What Specifically?					