Gentle Dental Health History

Patient Information

Patient Name_____Account #_____
First Middle Initial Last (office use only)

Address_____

City_____ ST _____ZIP_____

Home Phone _____ Cell Phone _____

Employer Phone_____Birthdate_____

E-mail:_____Social Security Number_____

Employer Name and Address_____

Marital Status: Married Single Divorced Widowed Patient Gender: M F

Spouse_____Spouse Birthdate_____

Spouse Employer_____Spouse SSN_____

Responsible Party(if different from above)

Name_____Relationship_____

Birthdate_____SSN_____

Employer_____Employer Phone_____

Dental Insurance Information

Policy Holder's Name_____Phone_____

Social Security Number_____Birthdate_____

Employer_____ Employer Phone_____

Insurance Company_____Group #_____ID Number_____

How did you hear about our office?_____

Reason for today's visit: toothache swelling lost filling accident
denture routine check up other_____

Medical Information

Emergency Contact (not living with you)_____
Name Phone Relationship

Medications currently taking_____

_____

***HAS ANY DOCTOR TOLD YOU THAT YOU NEED TO TAKE AN ANTIBIOTIC BEFORE DENTAL PROCEDURES DUE TO A MEDICAL CONDITION?**
PLEASE CIRCLE: YES NO

Allergies you have (Circle):

Anesthetic	Aspirin	Codeine	Keflex	Latex	Motrin
Penicillin	Sulfa	Tetanus	Tylenol	Other_____	

Please check all that apply and fill in dates:

__	AIDS/HIV	_____	__	LIVER/HEPATITIS	_____
__	ANEMIA	_____	__	LUNG/EMPHYSEMA	_____
__	ARTHRITIS	_____	__	MITRAL VALVE PROLAPSE	_____
__	ARTIFICIAL JOINT	_____	__	MURMUR (HEART)	_____
__	ASTHMA	_____	__	MIGRAINE	_____
__	BLEED EASILY	_____	__	MULTIPLE SCLEROSIS	_____
__	BLOOD PRESSURE	_____	__	ORGAN TRANSPLANT	_____
__	HIGH/LOW	_____	__	PACEMAKER	_____
__	BLOOD THINNERS	_____	__	PREGNANT DUE DATE	_____
__	BY PASS	_____	__	PSYCHOLOGICAL TREATMENT	_____
__	CANCER	_____	__	RHEUMATIC FEVER	_____
	__CHEMOTHERAPY	_____	__	SEIZURES	_____
	__RADIATION	_____	__	SURGERY-MAJOR	_____
__	DIABETIC	_____	__	THYROID	_____
__	FAINTING	_____	__	TOBACCO USE (TYPE)	_____
__	HYPOGLYCEMIA	_____	__	TUBERCULOSIS	_____
__	IRREGULAR HEARTBEAT	_____	__	ULCERS	_____
__	KIDNEYS/DIALYSIS	_____	__	OTHER_____	_____

Please read carefully

Gentle Dental requires payment at time service is rendered. We accept all major credit cards and debit cards. Deferred payment is available through an interest free account with qualified credit. Payment by check is accepted, however in the unlikely event your check is returned, we reserve the right to re-present the item electronically, plus the state allowed processing fee.

I authorize payment of group insurance benefits, otherwise payable to me, directly to Gentle Dental, PC. My signature is also a file signature for dental insurance. I understand any outstanding balance my insurance does not pay will be my responsibility.

I authorize Gentle Dental, PC. to verify my past and present credit references.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. We are required by federal and state law to maintain the privacy of your health information. We may use or disclose your health information for such reasons listed below: Another health care provider treating you, to obtain payment for services rendered, in connection with our healthcare operations, in reasonably suspected abuse or neglect cases, national security and for appointment reminders. You have the right to access, amend, request a disclosure accounting, and request alternative communications regarding your health information. All must be in writing. You are entitled to receive this notice in written form.

I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services, either in this instance or in any other treatment rendered by staff in this office, shall be submitted to binding arbitration under Chapter 679A of the Code of Iowa (2007) as amended. It is understood by both doctors and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, patient and doctors have given up their right to a jury or a court trial.

Gentle Dental requires advance notice if an appointment has to be cancelled or rescheduled. Please be advised after three missed appointments, Gentle Dental will not reserve appointments in advance.

Signed_____Date_____