Welcome!

GentleCare Dentistry
Patient Information

Patient Info:

Date:	Name:		
Date of Birth:	Marital Status: (Married/Sin./Div./Wid.)		
Name of Spouse (or parent if child):			
Street Address:	City:	State:	Zip:
Home #:	Work #:	Cell #:	
Patient Employer:	SS #		
How did you hear about us?			
Emergency Contacts:	Home Phone:	Work:	
1.			
2.			

Insurance Info:

Insurance Co.:	Subscriber Name:
Member ID#:	Subscriber DOB:
Group #:	Subscriber SS#
2nd Insurance Co.:	Subscriber Name:
Member ID#	Subscriber DOB:
Group #	Subscriber SS#:

Current Dental Condition

What is the reason for today's visit?			
Date of last cleaning?	Approx. date of last x-rays?		
How often do you visit your dentist for cleanings?			
How often to you brush?	How often do you floss?	Waterpick?	
Do you experience any of the following?			
Cold/Hot Sensitivity	Yes	No	
Bleeding Gums	Yes	No	
Bad Mouth Odors	Yes	No	
Frequent Cold Sores/Blisters	Yes	No	
Grinding/clenching of teeth	Yes	No	
Gum Disease/Tooth Loss	Yes	No	
Are you happy with the appearance of your teeth?	Yes	No	
Would you like to receive a complimentary cosmetic dental evaluation?	Yes	No	
Is there anything else we should know about your dental treatment?			

Current Medical Condition

Physician Name:	Office Phone:	
Have you been under the care of a medical doctor in the past two years?	Yes	No
If yes, please list nature of condition(s):		
Are you allergic to PENICILLIN? Yes No		
Do you have any other drug allergies? Yes No	If yes, please list below:	

GENTLECARE DENTISTRY
PATIENT INFORMATION SHEET

Medical History: Please circle any conditions you have or have had in the past.					
Heart Disease (Surgery, Attack, etc.)	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No
Congenital Heart Disease	Yes	No	Allergies/Hives	Yes	No
Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No
Artificial Heart Valve	Yes	No	Chemotherapy	Yes	No
Pacemaker	Yes	No	Tumors/Cancer	Yes	No
Rheumatic Fever	Yes	No	Hepatitis (Circle: A B C)	Yes	No
Arthritis/Rheumatism	Yes	No	Vernerial Disease	Yes	No
Cortisone Treatments	Yes	No	A.I.D.S.	Yes	No
Swollen Ankles	Yes	No	H.I.V. Positive	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No
Artificial Joints (i.e., hip,knee)	Yes	No	Blood Transfusions	Yes	No
Kidney Trouble	Yes	No	Hemophilia	Yes	No
Ulcers	Yes	No	Sickle Cell Disease	Yes	No
Diabetes	Yes	No	Bruise Easily	Yes	No
Thyroid Problems	Yes	No	Liver Disease	Yes	No
Glaucoma	Yes	No	Jaundice	Yes	No
Contact Lenses	Yes	No	Neurological Disorders	Yes	No
Chronic Cough	Yes	No	Epilepsy or Seizures	Yes	No
Tuberculosis	Yes	No	Fainting/Dizzy Spells	Yes	No
Emphysema	Yes	No	Psychiatric/Psychological Care	Yes	No
High Blood Pressure	Yes	No	Blood Transfusion	Yes	No
If you have answered "Yes" to any of the conditions above, please explain below:					
LIST CURRENT MEDICATIONS:					
For Women Only:					
Are you pregnant?	Yes	No	Are You Nursing?	Yes	No
Are you taking oral contraceptives?	Yes	No			

For your convenience, we accept Cash, Check, and All Major Credit Cards. Ask about our extended payment plans through CareCredit for major work and cosmetic makeovers.

PATIENT DECLARATIONS:

1. I have answered all questions to the best of my knowledge. Should further information be needed, GentleCare Dentistry LLC has my permission to ask the respective health care provider or agency who may then release this information. I will notify Dr. Anthony of any change in my health or medication.

2. I understand that I am responsible for all charges for dental services rendered to me. I understand that payment is due at the time of service. If applicable, I authorize my insurance company to pay benefits directly to Dr. Anthony. In the event my account becomes delinquent, I understand that I am responsible to pay actual collection and/or attorney fees.

PATIENT/GUARDIAN SIGNATURE: _____ _____

Date

Updates: Date_____, By_____; Date_____, By_____; Date_____, By_____