

Gentle Dental Care

www.texasgentledental.com

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION		
		Date _____
Patient _____		
Address _____		
_____	_____	_____
City	State	Zip
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Patient SS# _____		DL# _____
Occupation _____		
Employer _____		
Employer Address _____		
Employer Phone _____		
Spouse's Name _____		
Birthday _____		
Occupation _____		
Spouse's Employer _____		
Whom may we thank for referring you? _____		

2 DENTAL INSURANCE	
Who is responsible for this account? _____	
Relation to patient _____	
Insurance Co. _____	
Group # _____	
Is patient covered by additional Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name _____	
Birthday _____ SS# _____	
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
ASSIGNMENT AND RELEASE	
I, the undersigned certify that I (or my dependant) have insurance coverage	
With _____ and assign directly to	
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.	
_____	_____
Responsible Party Signature	Date
_____	_____
Relationship	

3 PHONE NUMBERS			
Home _____	Work _____	Ext _____	Cell Phone _____
Best time and place to reach you _____		Email Add. _____	
IN CASE OF EMERGENCY, CONTACT (<i>specify someone who does not live in your household</i>)			
Name _____		Relationship _____	
Home Phone _____		Work Phone _____	

4 DENTAL HISTORY			
Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	
Former Dentist _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	
City/State _____	Cigarettes, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last dental visit _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last dental X-rays _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No	
Place a mark on "Yes" or "No" to indicate	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have had the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blisters in lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
		How often do you brush? _____	