Gentle Family Dentistry Patient Registration (Please Fill in Form Then Print It & Bring It With You)

PATIENT INFO

NAME			NICKNAME	SEX	BIRTHDATE			MARITAL STATUS			
(Last)	(First)	(Middle initial)		(M) (F)	(Mo)	(Day)	(Yr)	(S)	(M)	(W)	(D)

SOCIAL SECURITY NUMBER	HOME ADDRESS			HOME PHONE
	(Street)	(City, State)	(Zip)	( )
OCCUPATION	BUSINESS NAME & ADDRESS			BUSINESS PHONE
(Nature of work, student, housewife)	(Street)	(City, State)	(Zip)	( )
SPOUSES NAME	BUSINESS PHONE ( )	CLOSEST RELATIVE NOT LIVING W/ YOU		THEIR PHONE ( )

GUARANTOR

NAME	HOME ADDRESS			HOME PHONE
(Person responsible for account)	(Street)	(City, State)	(Zip)	( )
EMPLOYER	ADDRESS			BUSINESS PHONE
	(Street)	(City, State)	(Zip)	( )
SOCIAL SECURITY NUMBER	PRIMARY DENTAL INSURANCE	CONTRACT NUMBER		GROUP NUMBER
BIRTHDATE	SECONDARY DENTAL INSURANCE	CONTRACT NUMBER		GROUP NUMBER

Medical History

PATIENT'S CELL PHONE NUMBER: **EMAIL ADDRESS:**

Physician: ________________________________ Address: ________________________________ Phone: ______________ **Is It OK To Call You At Work?** ☐ **YES** ☐ **NO**

Are you in good health? __________ If no, Explain: ____

Do you have an Existing Illness? __________ If yes, Explain: ____

Does Anyone in Your Family Have Diabetes? __________ Who? ________________________________

Has Anyone in Your Family Ever Had Gum Disease? ___________ Who? ________________________________

Are you taking any Medications/Drugs? ____________ Please List: ____

Have you ever had any allergic reaction to <u>any</u> drugs, metals or other substances Including Penicillin, Codeine, Novocaine, Aspirin, Tylenol, Other Antibiotics, Jewelry, Nickel, etc? ______________ Please List: ________________________________

Do you bleed excessively when cut? ____________ Do you use any tobacco products smoke, snuff, chew or other? ________________ If yes, what & How Much? ________________________________

Have you been Hospitalized in the past Two Years? ____________ If Yes, Explain: ____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF YES, DESCRIBE UNDER REMARKS . . . . . .

	YES	NO		YES	NO		YES	NO
1. HEART DISEASE	☐	☐	9. VENEREAL DISEASE	☐	☐	17. ANEMIA	☐	☐
2. HEART MURMUR	☐	☐	10. ULCERS	☐	☐	18. RADIATION TREATMENTS	☐	☐
3. HIGH BLOOD PRESSURE	☐	☐	11. SINUS TROUBLE	☐	☐	19. ASTHMA, EMPHYSEMA, LUNG DISEASE	☐	☐
4. BLOOD DISEASE	☐	☐	12. PSYCHOLOGICAL OR NERVOUS DISORDERS	☐	☐	20. GLAUCOMA	☐	☐
5. RHEUMATIC FEVER	☐	☐	13. ARTIFICIAL IMPLANTS	☐	☐	21. HEPATITIS, JAUNDICE	☐	☐
6. DIABETES	☐	☐	14. LIVER DISEASE	☐	☐	22. TUBERCULOSIS	☐	☐
7. STROKE	☐	☐	15. KIDNEY TROUBLE	☐	☐	23. AIDS OR TESTED POSITIVE FOR HIV	☐	☐
8. EPILEPSY	☐	☐	16. TUMORS OR GROWTHS	☐	☐	24. WOMEN, IF PREGNANT, DUE DATE _____ _________		

REMARKS:
____

Dental History

Have you ever been told by a physician to take antibiotics before a dental appointment? _____________

Do your gums bleed when you floss or brush them? _____________

Have you ever had severe or prolonged Bleeding after extraction of teeth? __________________

When was your last full mouth x-ray taken? ________________________________ Where? ________________________________

When was your last dental cleaning? ___________________________ What, if anything, are your Present dental complaints? ________________________________

Have you ever been instructed in: (a) The prevention of decay? ___________ (b) Caring for your gums? ___________ (c) Proper flossing and brushing technique? ______________

Do you wear removable partials or dentures? ______________ How old are they? ____________________________________ Are you happy with them? ___________________

If not happy, what don't you like about them? ____

I consent to whatever Dental Procedures and anesthetics are necessary for the treatment of the above named patient.
I also agree to assume Full Financial Responsibility for all treatment rendered.

Signature: ____ Date: ______________________________

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How do you feel about your teeth? ____

How do you feel about your smile? ____

What dental needs do you believe that you have right now? ____

If you could do anything to change the appearance of your teeth what would it be? ______________________

Would you like your teeth whiter? ❐ Yes ❐ No

Would you like your teeth straighter? ❐ Yes ❐ No

Why did you leave your last dentist? ____

Do we have your permission to do a credit check in case financing may be desired? ❐ Yes ❐ No

Financial Understanding

Please read and sign the following statement of understanding and agreement.

If you have dental insurance: I understand and agree that any third party insurance benefits which I may have are entirely my responsibility and I hold Gentle Family Dentistry and it's staff harmless for failure to collect any benefits which my carrier or employer has indicated may be due me.

As a courtesy, Dr. Locker and his staff will make every reasonable attempt to collect from the insurance company any benefits or payments due and assignable to them for any covered services they have rendered. But any of my insurance benefits which they have been unable to collect for any reason within 60 days following the rendering of that/those service(s) will become immediately due and payable by me personally, unless other advance arrangements have been made.

I also understand that I am immediately responsible upon rendering of services for any co-payments or deductibles imposed by my insurance company that may apply for any particular procedure(s).

For Periodontal (gum) Treatments: Most insurance companies pay very little for gum treatments, regardless of their claims. Therefore, if you need gum treatments, we will have to ask you to pay for them in full when the service is rendered. Any payments we may receive from your insurance company for those treatments will be credited or refunded to you.

If you have dental insurance with Blue Shield or United Concordia: Blue Shield sends ALL checks directly to the patient. I agree to immediately pay Gentle Family Dentistry in full when services are rendered and then keep these checks as reimbursement.

If you do not have dental insurance: I understand that, unless previous arrangements have been made with Dr. Locker or his financial coordinator, I am immediately responsible to pay in full for any services at the time they are rendered. I may pay by cash, check, Master Card, Visa, Discover, Debit Card or Care Credit.

Care Credit: I understand that if I have signed up for Care Credit or Chase Credit or any like plan I am completely responsible for making every payment to them on time even if for some reason I have elected to delay the start of treatment. I am also responsible for making & keeping the necessary appointments to secure the treatment that has been pre-paid for me.

Statement Finance Charge: Understanding the above, I further understand that Gentle Family Dentistry is not a finance company and cannot carry loans or debts. Therefore, without prior arrangements, any unpaid balance which I owe, after any third party insurance payments are deducted, will be billed to me on the next monthly statement which will carry with it a 10% per Month Statement Finance Charge on the unpaid balance. If I pay my entire balance within 30 days of the Statement Date I will not have to pay the 10% finance charge for that month. In other words, the only reason I would have to pay this high monthly service charge is if I fail to pay my bill when it is due.

____ ____________________

Signature of adult patient or legal guardian of minor Date