Gentle Smiles
OF WIND GAP

Your trusted home for comfortable dentistry

PATIENT INFORMATION

Chart #___________

Name ____ Title _______________ Today's Date ___________________________

Mailing Address ____ Social Security # _________________________

Physical Address ____ City, State & Zip ______________________________________

Home Phone ______________________ Work Phone ___________________________ Cell Phone ___________________________

Date of Birth ____ Email ____

Employer Name/ Address ____

Marital Status (please check box): Single [ ] , Married [ ] , Widowed [ ] , Divorced [ ] , Other [ ]_________________

Have other members of your family been to our office? Yes [ ] , No [ ] How did you hear about the office:__________________

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party (guardian) ___________________________________ Social Security # ____________________________

Relationship to patient (must be present) ________________________________ Date of Birth_________________________________

Address (if different than patient) ____ Occupation ____________________

Employer _________________________ Employer Address / Work Phone ____

Name of Responsible Party's Spouse __________________________________ Social Security # ______________________________

DENTAL INSURANCE

Insured Name ____ Insurance Company __________________________________

Insured DOB ____________________________ Subscriber ID ____

Relationship to patient _______________________________________ Social Security # ____________________________________

Group # ___________________________________ Employer ____

Employer Address / Work Phone ____

Insurance Co. Address (include city, state, zip) ____

Insurance Co. Phone # __________________________________

DENTAL HISTORY

Primary reason for this dental appointment: [ ] Examination , [ ] Emergency , [ ] Consultation

Do you have a specific dental problem? Describe ____

Name of previous dentist ___________________________________ Last dental visit______________________________________

Date of last full mouth or bitewing x-rays______________________ How often do you brush and floss? _________________________

What dental aids do you use? [ ] Water Pick [ ] Toothpick [ ] Electric toothbrush [ ] Perio Aid [ ] Other_________________

Please check any of the following which apply to you:

[ ] Gums bleed during brushing or flossing

[ ] Gums feel tender or swollen

[ ] Pain with brushing or flossing

[ ] Frequent sensitivity to: [ ] cold , [ ] hot , [ ] sweets

[ ] Usually break fillings or teeth

[ ] Pain with biting or chewing

[ ] Jaws frequently feel tired or sore

[ ] Jaw joint popping or clicking

[ ] Currently (or previously) used a mouthguard or splint

[ ] Frequent cold sores, blisters or other oral / lip lesions

[ ] Food frequently gets caught between teeth

[ ] Previous (or current) Periodontal (gum) surgery

[ ] Previous (or current) injury or trauma to your teeth, mouth or face

[ ] Previous (or current) biopsy of the mouth, lips or face

[ ] Bad odors or tastes in mouth

[ ] Regularly clench or grind your teeth

CONSENT FOR TREATMENT (Please sign unless you have any questions)

I herby authorize this Dental Practice to administer and perform the necessary procedures, such as x-rays, anesthetic, and dental treatment deemed necessary or advisable with the diagnosis of myself or the minor's dental condition. I understand there are certain risks inherent in dental treatment, such as but not limited to: Pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia, and other procedure specific risks. I agree to be responsible for any bills incurred on behalf of myself or the minor during their dental treatment.

FAILED OR CANCELED APPOINTMENTS

We kindly ask that patients give us 24-hour notice, if they are unable to keep an appointment. There will be a $25 minimum charge for failed appointments. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice. You may leave a message on our after-hours message phone, if you find out that you are unable to honor an appointment after our office has closed for the day.

NOTICE OF PRIVACY PRACTICES (HIPPA)

A laminated copy of our office Notice of Privacy Practices (HIPPA) displayed in the office which you are being asked to complete. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices. Please let us know if you have any questions or concerns about any of our office policies: otherwise please sign below.

Patient Signature (Parent or Guardian):____________________________________ Date:__________________________