Gentle Dental Care

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PATIENT REGISTRATION

Patient's Name _____ Birthdate___/___/___ Marital Status___Home Phone_____

Residence Address _____ Apt.#_____City_____ State_____ Zip_____

Employed By _____ Business Address_____

Business Phone _____ Position Held_____ Driver's License #_____

Social Security # ___ ___ ___-___ ___-___ ___ ___ ___Automobile License Plate #_____

Spouse's Name _____ Spouse's Employer_____ Spouse's Business Phone_____

Spouse's Business Address _____ Position Held_____

Nearest Relative _____ Relative's Home Address_____ Relative's Home Phone_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name_____ Birthdate___/___/___ Home Phone_____

Residence Address _____ Apt.#_____City_____ State_____ Zip_____

Employed By _____ Social Security # ___ ___ ___-___ ___-___ ___ ___ ___ ___

Primary Insurance Company Address _____

City _____ State_____ Zip_____ Primary Insurance Policy #_____

Secondary Insurance Company Address _____

City _____ State_____ Zip_____ Secondary Insurance Policy #_____

DENTAL HISTORY

Purpose of this visit? _____

Are you having any discomfort at this time? _____

How long since you have been to a dentist? _____

What was done then? _____

Has the fear of discomfort kept you from regular dental visits? _____

Would you like to try Nitrous Oxide (tranquilizing air) to relieve apprehension? _____

When & how often do you brush your teeth? _____

When & how often do you floss your teeth? _____

Do you use any other cleaning device? _____

How long do you use a toothbrush before replacing it with a new one? _____

Do your gums bleed easily, feel tender or irritated? _____

Have you ever had gum treatments? _____ When? _____

Are your teeth sensitive to heat? _____ to cold? _____ to sweets? _____

Does food wedge between your teeth? _____ where? _____

Do you hear popping, clicking, or snapping noises when you chew? _____

Are you aware of any swelling or lump in your mouth? _____

Do you feel you are troubled with bad breath? _____

Are you self-conscious about the appearance of your teeth? _____

Would you like a free 5 minute "Smile Analysis"? _____

Do you want to avoid dentures? _____

Do you want to know how you can keep the natural teeth you still have? _____

Do you want to learn how your children may keep their natural teeth for a lifetime without discomfort? _____

MEDICAL HISTORY

Physician's Name _____ Physician's Address _____

Do you have, or have you had, any of the following? Please indicate with a check mark(√).

_____	Diabetes or frequent thirst	_____	Epilepsy	_____	Tuberculosis
_____	Hepatitis or jaundice	_____	Prolonged bleeding	_____	Psychiatric Shock Therapy
_____	Rheumatic Fever	_____	Fainting tendency	_____	Nasal obstruction
_____	Any heart problems	_____	AIDS/HIV Positive	_____	Multiple Sclerosis
_____	Abnormal blood pressure	_____	Cancer	_____	Bad experience with general anesthetic
_____	Chest pain, shortness of breath	_____	Radiation Treatments	_____	Any other operations
_____	Anemia or blood disease	_____	Sinus problems		
_____	Any recent medical treatment	_____	Severe headaches		

List the name of any of the following types of drugs that you are taking:

Cortisone Drugs, Steroids, ACTH, or Anti-Rejection drugs: _____

Anti-coagulants or blood thinners: _____

Tranquilizers or sedatives: _____

List any other drugs that you are taking: _____

Are you allergic to penicillin: _____

List any other drugs that you are allergic to: _____

List any other drugs that you cannot take: _____

Are you pregnant (women only, please): _____

Your signature _____ Date _____

Thank you taking the time to complete this form so that we may better help you.