

Gentle Family Dentistry & Orthodontics  
Sage L. White, DDS, FAGD, PC

# WELCOME

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Check Appropriate Box:  Male  Female  Minor  Single  Married

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY (SAME NAME AS ON FINANCIAL ARRANGEMENT)

Name of Person Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_ Bank \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Currently a Patient Here?  Yes  No

## DENTAL INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used This Year? \_\_\_\_\_ Max. Annual Benefit? \_\_\_\_\_

## ADDITIONAL DENTAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used This Year? \_\_\_\_\_ Max. Annual Benefit? \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Check (✓) if you have or ever had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bad Breath               | <input type="checkbox"/> Grinding teeth              | <input type="checkbox"/> Sensitivity to heat      |
| <input type="checkbox"/> Bleeding gums            | <input type="checkbox"/> Loose teeth/broken fillings | <input type="checkbox"/> Sensitivity to sweets    |
| <input type="checkbox"/> Ringing in the ears      | <input type="checkbox"/> Periodontal treatment       | <input type="checkbox"/> Sensitivity when biting  |
| <input type="checkbox"/> Food collection in teeth | <input type="checkbox"/> Sensitivity to cold         | <input type="checkbox"/> Sores or growth in mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Have you ever experienced "TMJ" problems, (clicking, or grinding of the jaw joint while opening and closing the mouth)? \_\_\_\_\_

Do you have problems with snoring? \_\_\_\_\_ Do you generally feel tired during the day? \_\_\_\_\_ Do you have problems with sleep apnea or waking up frequently during the night? \_\_\_\_\_

Is there anything about your mouth that concerns you? \_\_\_\_\_ If so, what? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate date \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have ever had any of the following:

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding      | <input type="checkbox"/> Cancer – Chemotherapy   | <input type="checkbox"/> Fever Blisters      | <input type="checkbox"/> HIV+ AIDS             | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Alcohol Abuse          | <input type="checkbox"/> Colitis                 | <input type="checkbox"/> Frequent Headaches  | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Cosmetic Surgery        | <input type="checkbox"/> Hay fever           | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Angina Pectoris        | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Heart Surgery       | <input type="checkbox"/> Pace Maker            | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Artificial Bones       | <input type="checkbox"/> Drug Abuse              | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Pneumocystitis        | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Hepatitis A         | <input type="checkbox"/> Psychiatric Problems  | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Radiation Therapy     | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Yellow Jaundice     |

### MEDICATIONS

### ALLERGIES

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of dentist

\_\_\_\_\_  
Date