# Patient Registration Form
# Gentle Care Dentistry & Implants
# 520-458-9460

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|---|---|
| **Today's Date:** | **Referred by:** |
| **Name:** | **SS#:** |
| **Address:** | **Date of Birth:** |
| **How would you prefer us to contact you?<br>Email/Text/Home or Work ph?** | **Cell #:<br>Work #:** |
| **Home #:** | **Email:** |

## Dental Insurance Information

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|---|---|
| **Name of Insured:** | **Relationship to patient: self/spouse/child** |
| **Insured SS#:** | **Insured Date of Birth:** |
| **Insurance Company:** | |

## Secondary Insurance Information

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|---|---|
| **Name of Insured:** | **Relationship to patient: self/spouse/child** |
| **Insured SS#:** | **Insured Date of Birth:** |
| **Insurance Company:** | |

## Dental Information

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|---|---|
| **Do your gums bleed when you brush or floss? Y N** | **Do you have earaches or neck pain? Y N** |
| **Are your teeth sensitive to hot, cold, pressure or sweets? Y N<br>(Circle all that apply)** | **Do you drink bottled or filtered water? Y N<br>How often?** |
| **Is your mouth dry: Y N** | **Do you brux or grind your teeth? Y N** |
| **Have you had any periodontal (gum) treatments? Y N** | **Have you ever had orthodontic (braces) treatment? Y N** |
| **Do you have sores or ulcers in your mouth? Y N** | **Do you wear partials or dentures? Y N** |
| **Have you had any problems associated with previous dental treatment? Y N** | **Do you participate in recreational activities? Y N** |
| **Is your home water supply fluoridated? Y N** | **Do you have clicking, popping or discomfort in the jaw? Y N** |
| **Have you ever had a serious injury to your head or mouth?<br>(Describe briefly if Y)** | **Are you currently experiencing dental pain or discomfort? Y N<br>(Describe briefly if Y)** |
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## Women Only

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|---|---|
| **Do you take birth control pills or hormone replacement therapy? Y N** | **Pregnant?<br>How many weeks?<br>Nursing?** |

## Medical Information

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|---|---|
| Primary Care Physician:<br>Phone # | Have there been any changes in your health in the past year? (Describe briefly, if Y) |
| Have you had a serious illness, operation or been hospitalized in the past 5 years? (Describe briefly, if Y) | Are you taking, or have you taken any diet drugs such as Pondinmin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phenterminecombination)? Y N |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? Y N Date began: | Are you taking or scheduled to begin taking either of the medications Fosamax (alendrontate) or Actonel (risendronate) for osteoporosis or Paget's disease? Y N |
| Do you use tobacco? Y N (If Y cigarettes/cigars/chew/snuff)<br>Are you interested in quitting? Y N Maybe | Do you drink alcohol? Y N<br>How many drinks per week? |

## Allergies- circle all that apply

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|---|---|
| Local anesthetics | Metals |
| Aspirin | Latex (rubber) |
| Penicillin or other antibiotics | Iodine |
| Barbituates, sedatives or sleeping pills | Sulfa Drugs |
| Codeine or other narcotics | Seasonal, animal, food or other |

## Medications

| Please list any medications including vitamins, natural, herbal or diet supplements: |
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## Medical Conditions-circle all that apply

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|---|---|---|---|
| Heart murmur | Anemia | Chest pain upon exertion | Contact Lenses |
| Mitral valve prolapse | Abnormal bleeding | Eating disorder | Kidney problems |
| Artificial heart valve | Rheumatic heart disease | Malnutrition | Night sweats |
| Rheumatic fever | Hemophilia | Gastrointestinal disease | Osteoporosis |
| Cardiovascular disease | Pacemaker | Ulcers | Systemic lupus erythemyatosus |
| Angina | Arthritis | Thyroid problems | G.E. Reflux/ Persistent heartburn |
| Arteriosclerosis | Autoimmune disease | Stroke | Persistent swollen glands in neck |
| Congestive heart failure | Rheumatoid arthritis | Glaucoma | Severe headache/migraine |
| Coronary artery disease | Asthma | Hepatitis, jaundice or liver disease | Diabetes Type I or II |
| Damaged heart valves | Bronchitis | Epilepsy | Excessive urination |
| Heart attack | Emphysema | Fainting spells or seizures | Chronic pain |
| Low blood pressure | Sinus trouble | Sleep disorder | Sexually transmitted disease |
| High blood pressure | Tuberculosis | Severe or rapid weight loss | AIDS or HIV infection |
| Congenital heart disease | Mental health disorder<br>If Y, specify | Recurrent infections<br>Type of infection: | Neurological disorders<br>If Y, specify: |
| Blood transfusion<br>If Y, date: | Cancer/Chemotherapy/Radiation treatment | Joint replacement<br>Date and what: | Sleep related disorders |

# A Word About Insurance
# Gentle Care Dentistry & Implants
## 520-458-9460

We appreciate your confidence in our office and are proud to welcome you as a new part of our dental family. We are finding that insurance companies are becoming less cooperative as time goes by. As a courtesy we will submit claims to your insurance and do all we can to cooperate with the requirements and requests made by your carrier. Please note that there are never any payment guarantees. There are times when insurance companies deny payment for treatment recommended by the dentist. If we are in network with your insurance, the fees we provide to you are based on their official fee schedule. Every insurance policy has certain restrictions, so please take the time to understand your specific plan. Also be aware there are many different policies within each insurance, even within employers specific plans offered. Your policy is an agreement between you and your insurance company and not between you and Dr. Hales. We know you have many choices for dentists here in town. We are glad you chose us!

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Patient Signature (legal guardian if patient is a minor)

# HIPPA Privacy Form
# Gentle Care Dentistry & Implants
## 520-458-9460

Acknowledgement of receipt of Notice of Privacy Practices

This signed agreement acknowledges receipt of our Notice of Privacy Practices and documents our good faith effort to obtain that acknowledgement.

I have received a copy or explanation of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian Date