

Annette Merlino
Gentle Family Dentistry
Patient Information



Name _____ Birthdate _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Spouse or Parent's Name _____ Employer _____
Person to contact in case of Emergency _____ Phone _____
Previous Dentist _____
How long since last visit? _____ Last X-Rays? _____
Whom may we thank for referring you? _____

Insurance Information

Name of insured _____ relationship to patient _____
Birthdate of Insured _____ Soc. Sec. # of Insured _____
Name of employer _____ Insurance company _____
Group # _____ Policy/ID # _____ How much is your deductible _____
Maximum annual benefit _____

Authorization and Release

I certify that I have read and understand all of the information to the best of my knowledge. All of the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payors. And/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent if minor) _____ Date _____

Please complete back of form

Patient Medical History

		Yes	No
1. Do you need, or think you may need, pre-medicated before your dental appointment?		___	___
2. Are you under medical treatment now? If yes, for what? _____		___	___
3. Are you taking any medications including non-prescriptive medicine? If yes, what medications are you taking? _____		___	___
4. Do you use tobacco?		___	___
5. Women only: Are you pregnant or think you may be pregnant? Are you taking oral contraceptives?		___	___
6. Are you allergic to, or ever had an adverse reaction to, any of the following?		___	___
	Yes No	Yes	No
Erythromycin	___ ___	___	___
Other Medications	___ ___	___	___
Penicillin	___ ___	___	___
Latex Rubber	___ ___	___	___
Tetracycline	___ ___	___	___
Local Anesthetics	___ ___	___	___
If yes, what other? _____			
7. Have you ever had, or do you now have, any of the following?		___	___
	Yes No	Yes	No
Mitral Valve Prolapse	___ ___	___	___
Heart Disease	___ ___	___	___
Cardiac Pacemaker	___ ___	___	___
Heart Murmur	___ ___	___	___
Heart Attack	___ ___	___	___
Angina	___ ___	___	___
Chest Pains	___ ___	___	___
Rheumatic Fever	___ ___	___	___
Low Blood Pressure	___ ___	___	___
High Blood Pressure	___ ___	___	___
Anemia	___ ___	___	___
Aids or HIV Infection	___ ___	___	___
Other information we should know. _____		___	___
	Yes No	Yes	No
Cancer	___ ___	___	___
Radiation Therapy	___ ___	___	___
Fainting/Seizures	___ ___	___	___
Leukemia	___ ___	___	___
Swollen Ankles	___ ___	___	___
Emphysema	___ ___	___	___
Asthma	___ ___	___	___
Stroke	___ ___	___	___
Diabetes	___ ___	___	___
Tuberculosis	___ ___	___	___
Thyroid Problem	___ ___	___	___
Sexually Transmitted Diseases	___ ___	___	___
Stomach troubles	___ ___	___	___
Kidney Disease	___ ___	___	___
Epilepsy/Convulsions	___ ___	___	___
Allergies/Hayfever	___ ___	___	___
Respiratory Problems	___ ___	___	___
Joint Replacement	___ ___	___	___
Joint Implant	___ ___	___	___
Arthritis	___ ___	___	___
Hepatitis/Jaundice	___ ___	___	___
Liver Disease	___ ___	___	___

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	___	___
2. Do you feel pain to any of your teeth?	___	___
3. Do you have any sores or lumps in or near your mouth?	___	___
4. Have you had any head, neck or jaw injuries?	___	___
5. Have you ever had any difficult extraction in the past?	___	___
6. Do you like your smile?	___	___
7. Do you wear dentures or partials? If so date of placement _____	___	___
8. Do you have dental implants?	___	___
8. Have you ever had any prolonged bleeding following extractions?	___	___
9. Have you received oral hygiene instructions regarding the care of your teeth or gums?	___	___
10. Have you ever experienced any of the following problems in your jaw? (circle if any)	___	___
Clicking, Pain in joint, ear, or side of face, difficulty in opening or closing, or difficulty in chewing		
11. Are your teeth sensitive to hot, cold, sweet or sour liquids/foods?(Circle if any)	___	___