Annette Merlino DMD
Gentle Family Dentistry

Name_____Age_____Birth date_____Sex_____

Address_____City_____State_____Zip_____

Home #_____Cell #/Carrier_____Work Phone_____

E-mail_____Emergency Contact_____Phone_____

Employer_____Social Security #_____Occupation_____

Marital Status_____How were you referred to us?_____

Spouse/Parent's name_____Contact Phone_____

Insurance Information

Primary Insurance

Subscriber Name_____Relationship to patient_____

Subscriber Birth date_____Social Security #_____

Subscriber employer_____Insurance Company_____

Group #_____Policy/ID#_____Deductible_____

Maximum yearly benefit_____Does pat. have a secondary ins.?_____

Secondary Insurance

Subscriber Name_____Relationship to patient_____

Subscriber Birth date_____Social Security #_____

Insured employer_____Insurance Company_____

Group #_____Policy/ID#_____Deductible_____

Maximum yearly benefit _____

Authorization and Release

I certify that I understand all of the questions and have answered them accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and treatments rendered to me or my child during the period of such Dental care to third party payers, and or health practitioners. I authorize and request my Insurance Company to pay directly to the dentist or dental group 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 on my behalf or my dependents. **I further recognize that I may be charged interest for balances that are more than three months outstanding and any further fees incurred during the collection process.**

X_____Date_____

Signature of patient (or parent/guardian if minor)

Health History

Are you allergic or have you ever had a reaction to any of the following?

___ Aspirin	___ Codeine	___ Iodine	___ Local Anesthetic	___ Sulfa Drugs
___ Barbiturates	___ Erythromycin	___ Latex Rubber	___ Penicillin	___ Tetracycline

Other: _____

Are you currently under a physicians care? _____ If yes, for what? _____

Physicians name _____ Last Visit _____ Phone #_____

Please list all medications you are taking and the correlating diagnosis:_____
_____
_____

Have you ever had or currently do have any of the following? **Check only those that apply.**

___ Abnormal Bleeding	___ Blood Transfusion	___ Low Blood Pressure
___ Allergies	___ Diabetes	___ Mitral Valve Prolapse
___ Anemia	___ Difficulty Breathing	___ Rheumatic Fever
___ Angina Pectoris	___ Epilepsy	___ Sinus Trouble
___ Arthritis	___ Headaches	___ Stroke
___ Artificial Joints	___ Glaucoma	___ Swelling Limbs
___ Artificial Valve	___ Hemophilia	___ Thyroid Problems
___ Asthma	___ High Blood Pressure	___ Tuberculosis
___ Back Issues	___ Kidney Disease	___ Ulcers

___ Heart Attack; If yes when? _____ Were you given a Pace maker/Defibrillator? _____
___ Hepatitis; If yes which type? _____
___ Sexually Transmitted Disease; If yes please specify _____
___ Cancer; If yes did you have radiation? _____ Did you have Chemotherapy? _____
___ Tobacco use; If yes what type and how often? _____

Please list any other medical information that you feel is important for us to know. _____
_____
_____

Women only

___ Are you pregnant or think you are pregnant? If yes what is your Due Date? _____
___ Are you nursing?
___ Are you using birth control? If yes please specify _____
(Please note some birth control medications can effect blood pressure and cause health risks.)

Dental History

Previous Dentist _____ Last Dental Visit _____

Please list any dental issues you are having or any previous issues such as, bleeding gums, pain, sores or abnormal growths in mouth._____
_____
_____

Acknowledgment of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact the practice for further information.

X_____Date_____
Signature of patient (or parent/guardian if minor)