GENTLE DENTAL

1 PATIENT INFORMATION

Date ____________ SS# ____________

Patient ____________

Address ____________

____
City State Zip

Driver's License # ____________

Sex: ☐ M ☐ F Age ______ Birthdate ____________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School/College ____________

____
City State ☐ FT ☐ PT

Employer ____________

Employer Address ____________

Employer Phone (____)____________

Spouse's Name ____________

Spouse's Employer ____________

Whom may we thank for referring you? ____________

____

2 DENTAL INSURANCE

Do you have Dental Insurance? (If yes, continue)____________

____

Policy Holder's Name ____________

Birthdate ____________ SS# ____________

Employer ____________

Insurance Co. ____________

Insurance Co. Ph. # (____)____________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with ____________and assign directly to Dr. David F. Sweeney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____________ ____________
Relationship Date

3 PHONE NUMBERS

Home (____)____________ Work (____)____________ Ext____________ Cell Ph. # (____)____________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____________ Relationship ____________

Home Phone (____)____________ Work Phone (____)____________

4 DENTAL HISTORY

Reason for today's visit____________

____

Former Dentist ____________

City/State ____________

Previous Dental Problems____________

____

Date of last dental visit ____________

Date of last X-rays ____________

Place a Mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Do you have more than two crowns ☐ Yes ☐ No
Do you grind your teeth ☐ Yes ☐ No
Do you routinely take Analgesics? (Aspirin, Tylenol, Motrin.) ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No
Worn teeth ☐ Yes ☐ No
How often do you floss? ____________
How often do you brush? ____________