Gentle Dental Family Dentistry Inc.

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(727) 302-9401 **Office**
(727) 388-2738 **Fax**
(727) 688-4327 **Emgcy #**

* Date: ____/____/ 20_____

Thank you for selecting our Dental Healthcare Team!
We will strive to provide you with the very best dental care possible.
Please complete and sign both sides of this form.

Pa. #: ________________

Patient Information -- (confidential): Age: ________ Birthday: ____/_____/_____ Home #: (_____)______-__________ Email: ________________________

NAME: ____ Cell # : (_____) _______-__________ OK to Text ☐
(First) (M.I.) (Last)

ADDRESS: ____________________________________ City: ______________________ State: ______ Zip: ____________

Check appropriate: Minor (__) Single (__) Married (__) Divorced (__) Widowed (__) Separated (__)

Patient's or Parent's Employer: ____ Work #: (_____) _______-____________

Business Address: ____________________________________ City: ______________________ State: ______ Zip: ____________

Spouse or Parent's Name: ______________________________ Employer: ____________________ Work #: (_____) _______-____________

Student's School/College: ____________________________________ City: ______________________ State: ______ Zip: ____________

***Whom may we thank for referring you?** ____

Emergency Contact: NAME: ____ Phone #: (_____) _______-___________
(First) (Last)

Relationship to Patient: ______________________________ Cell #: (_____) _______-___________ Work #: (_____) _______-___________

Name of Responsible Party: ____

Relationship to Patient: ______________________________

Address: ____________________________________ City: ______________________ State: _________ Zip: _____________

Driver's License #: ______________________________Birth Date: ____/_____/________ Financial Institution: ______________________________

Employer: ______________________________________Work #: (_____)______-_________ Ext. _______ Home #: (______) _______-___________

Insurance Information:

Name of Insured: ____ Relationship to Patient: ______________________________

Birth Date: _____/______/_________ Social Security #: ________--______--__________ Date Employed: _____/______/_______ Work #: (_____) ______--___________

Employer: ______________________________ Address: ______________________________ City: ______________________

Insurance Company: ______________________________ Tel. #: (______)________-__________Group #: ________________ Union/Local #: ________________

Ins. Co. Address: ____________________________________ City: ______________________________ State: _____ Zip: ______________

How much is your deductible? ________________________ How much have you used? ____________________________ Annual maximum: ____________________

Acknowledge of receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for
Gentle Dental Family Dentistry Inc., Dr. Gabriele Spinuso, DDS.

This _____________ day of___________________, 20________. A copy of this signed and dated acknowledgment shall be as effective as the original

____ X____
Printed Name Signature

If you are the legal representative of the patient, please print the patient's name and describe your authority:______________________________

Thank you, if you have any questions about this form or the attached Notice, please contact our Privacy Officer or Myself.

------------------------------ ***Office use only*** ------------------------------

As Privacy Officer, I attempted to obtain the patient's or representative's signature on this Acknowledgment but did not because:

____It was an emergency treatment ____I could not communicate with the patient. ____The patient refused to sign

The patient was unable to sign because____

_____Other (please describe): ____

*Privacy Officer Signature*____

Name: ______________________ **Medical Alerts:** ______________________ **Patient ID #:** __________

Patient: ______________________________ **Age:** ________ **Allergy:** ______________

Patient Medical History

Physician: ______________________ Office #: (______) ______-_______ Blood Pressure: ------/-------- Last Examination: _____/_____/_______

Pharmacy Name: ________________________________ Tel #: (_____) ______ - ___________

1. Are you under medical treatment now? Y___ N___
Describe: ____
____
____

2. Ever been hospitalized for any surgical operations or serious illness?
List: ____
____
____

3. Taking any medications? (Prescription or Over the Counter) Y___ N___
If yes, what medications / amounts: ______________________________
____
____
For what condition(s): ______________________________________
____
____

4. Do you use tobacco? Y_____ N_____

5. Do you use: Alcohol _____ Cocaine _____ Other Drugs_____
List: ____

6. Are you allergic to/ or had a reaction to any of the following?
Local anesthetics (ex. Novocaine): Y _____ N_____
Penicillin: Y _____ N_____
Sulfa Drugs: Y _____ N_____
Barbiturate: Y _____ N_____
Other Antibiotics: ___________________________
Sedatives: Y _____ N_____
Iodine: Y _____ N_____
Aspirin: Y _____ N_____
Other meds: ______________________________

7. Women Only:
Pregnant?(____) Nursing?(____) Birth Control Pills?(____)

8. Are you wearing contact lenses? Y____ N_____

9. Do you have or have you ever had any of the following? (Check all that apply, give details as needed)

High blood pressure: ____ Controlled? _____

Low blood pressure: ____ How low? ____/____

Heart Disease: ____

Heart attack: ____ When: ___________

Stroke: ____ When: __________________

Angina/chest pain: ____ Last Time? _________
(Do you have Nitroglycerin tablets): _______

Cardiac pace maker: _____

Rheumatic fever: ____ (Require antibiotic prophylaxis prior to dental treatment?): ______

Heart murmur: ____ (Require antibiotic prophylaxis prior to dental treatment?): ______

Frequently tired: ____

Swollen ankles: ____

Epilepsy / Convulsions: ____
Last time: ________ meds: _________________

Fainting / Seizures: ____ Last time: ________
Duration: ______________

Arthritis: ____

Liver disease: ____

Glaucoma: ____

Respiratory problems: _____

Tuberculosis: ____

Emphysema: ____

Hay fever allergies: _____

Easily winded: ____

Asthma: ____ Carry an Inhaler? _____
Last time used? _________Worked Ok? ______

Cancer: ____ When: ____________________
Where/Type: ____________________________
Treatment / Medications: __________________
____
____
____

Leukemia: ___ Treatment: ________________

Radiation therapy: ____ How long ago? ______
Reason? _______________________________
Amount given? ___________________________

Recent Weight Loss: _____

Diabetes: ____ Type: _______ Last A1C:______
Meds: __________________________________

Kidney disease: ____

Hepatitis / Jaundice: ____ (Type): ___________
Medications: ____________________________

Joint replacement: ______ (Require antibiotic prophylaxis prior to dental treatment?): ________

Implant: _____ (Require antibiotic prophylaxis prior to dental treatment?): _______

AIDS or HIV infections: ______
(Medications / Dosage______________________
____

Sexually transmitted diseases: ____
Describe/List: ___________________________
Medications: ____________________________

Thyroid problems: ______
Medications: ____________________________

Stomach troubles / ulcers: _____
Medications: ____________________________

Bisphosphonates therapy (ex. Fosamax, Boniva…IV Meds… etc.): ______
List: ___________________________________

****Use this line to explain/elaborate further on any conditions above:** ______________________________

*X*____ **Date** _____/____/______

Signature of Patient or (Parent/Guardian if Minor)

Medical History Update:

Date	*Comments*	*Pt. Initials*	*Dr. Initials*	*Date*	*Comments*	*Pt. Initials*	*Dr. Initials*

Gentle Dental Family Dentistry Inc.

Dental History

Do your gums bleed? ___________

Are your teeth sensitive to any of the following? (Circle all that apply)**:**

Hot - Cold - Sweets - Sour - Pressure

Please indicate which areas: R L

Do you have any sores or lumps in/near your mouth? _________________

Have you had any head or neck injuries? ______When: _____/_____/_____

Do you have any jaw problems such as *Clicking* or *Popping*? ___________

Clicking: _______Where? ________________________________

Popping: _______Where? ________________________________

Would you like to whiten your teeth? ____________

Interested in a Snore Guard ___________

Interested in "Six Month Smiles –clear braces" ____________

Any fear of the dentist or previous bad experience? ____________________

Difficulty opening or closing jaw? _________

Chewing? ____________________

Orthodontic Work? _____________

Clenching Teeth? ______________

Grinding Teeth? _______________

Have you ever had difficult extractions in the past? ________

Prolonged Bleeding? ________

Getting Anesthetized? _______

Dry Socket? ________

Have you had proper instruction on:

Brushing? ________

Flossing? _________

Do you use a WaterPik/Flosser? ______ **Mechanical toothbrush?**______

Last cleaning and exam: 3 mo____ 6 mo____ 1 yr____ 2 yr____ longer

Please describe the main reason for visiting today. Please include overall goals, concerns and esthetic desires: __________________________________

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate 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 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 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 myself or my dependents, including Collection fees, Court costs and Attorney fees.

X____ **Date**________/_______/___________

Signature of Patient or (Parent/Guardian if Minor)

--- Office Use Only Below This Line----

Doctor's Comments

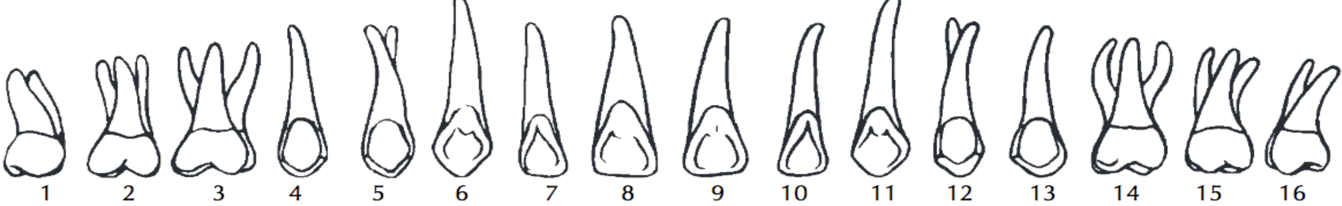
#	X-rays	Date
_____	BWX's	___/____/____
_____	Panx	___/____/____
_____	PA's	___/____/____

Doctor's Signature: ________________________________ **Date**________/_______/___________

Date		

Name: ______________________________ **Medical Alerts:** ____________________________ **Patient ID #:** ____________

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Date
Facial																	5.
																	4.
																	3.
																	2.
																	1.



Lingual																	1.
																	2.
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																	Date
Lingual																	5.
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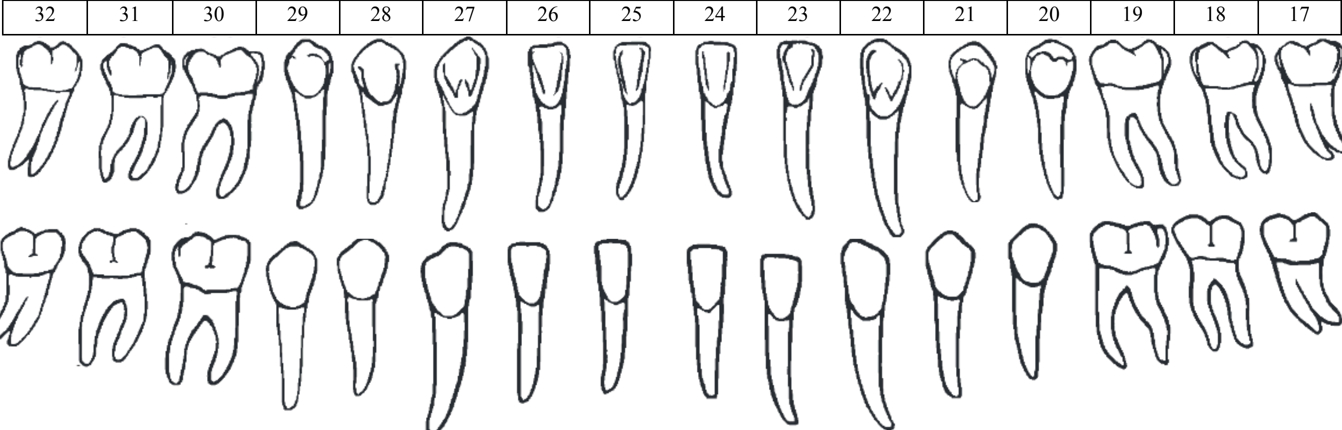
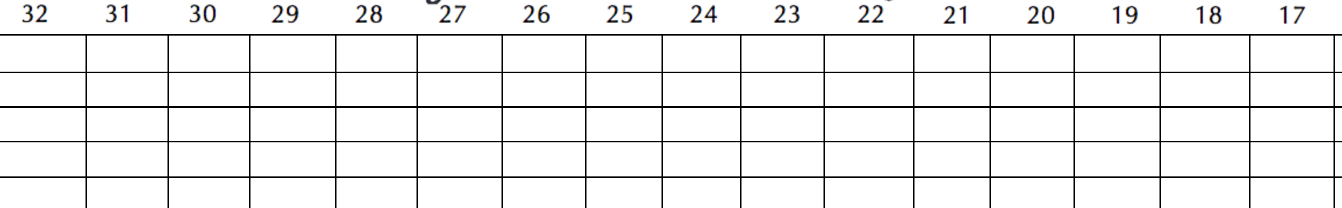
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	





	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Date
Facial																	1.
																	2.
																	3.
																	4.
																	5.

Significant periodontal findings or recommendations:

1. Date: ____________

___

2. Date: ____________

___

3. Date: ____________

___

4. Date: ____________

___