GibbsDentistry

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FOR OUR RECORDS

(complete both sides)

Patient Information *(Confidential):*

Name _____ Date _____

SS Number _____ Birth Date _____ Home Phone _____

Address _____ City _____ St _____ Zip _____

Email _____ Cell Phone _____

Communication Preference: ☐ E-Mail ☐ Text

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Parent/Guardian's Name _____ Cell Phone _____

Employer _____ Work Phone _____

Business Address _____ City _____ St _____ Zip _____

Emergency contact person _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party:

Name of Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ St _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment: (Please check the option you prefer)

☐ Cash ☐ Personal check Credit Card: ☐ VISA ☐ Master Card ☐ I wish to discuss the office's payment policy.

Insurance Information:

Name of Policyholder _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

Ins. Company _____ Group # _____ Policy/ID# _____

Ins. Company Address _____ City _____ St _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Policyholder _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

Ins. Company _____ Group # _____ Policy/ID# _____

Ins. Company Address _____ City _____ St _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

MEDICAL HISTORY

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now? □Yes □No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? □Yes □No If yes, please explain:_____

_____

Have you ever had a serious head or neck injury? □Yes □No If yes, please explain:_____

_____

Are you taking any medications, pills or drugs? □Yes □No If yes, please explain: _____

_____

Have you ever taken Fosamax, Boniva, Actonel, or any other bisphosphonate/antiresorptive bone medication? □Yes □No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? □Yes □No If yes, please explain:_____

Are you on a special diet? □Yes □No Do you use tobacco? □Yes □No Do you use controlled substances? □Yes □No

Women: Pregnant/trying to get pregnant? □Yes □No Taking oral contraceptives? □Yes □No Nursing? □Yes □No

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Acrylic □Metal □Latex □Local Anesthetics □Other Please explain: _____

_____

Do you have, or have you had, any of the following?

AIDS/HIV positive	□Yes □No	Excessive bleeding	□Yes □No	Lung disease	□Yes □No
Alzheimers disease	□Yes □No	Excessive thirst	□Yes □No	Mitral valve prolapse	□Yes □No
Anaphylaxis	□Yes □No	Fainting spells/dizziness	□Yes □No	Pain in jaw joints	□Yes □No
Anemia	□Yes □No	Frequent cough	□Yes □No	Parathyroid disease	□Yes □No
Angina	□Yes □No	Frequent diarrhea	□Yes □No	Psychiatric care	□Yes □No
Arthritis/Gout	□Yes □No	Frequent headaches	□Yes □No	Radiation treatments	□Yes □No
Artificial heart valve	□Yes □No	Genital Herpes	□Yes □No	Recent weight loss	□Yes □No
Artificial joint	□Yes □No	Glaucoma	□Yes □No	Renal dialysis	□Yes □No
Asthma	□Yes □No	Hay fever	□Yes □No	Rheumatic fever	□Yes □No
Blood disease	□Yes □No	Heart attack/failure	□Yes □No	Rheumatism	□Yes □No
Blood transfusion	□Yes □No	Heart murmur	□Yes □No	Scarlet fever	□Yes □No
Breathing problem	□Yes □No	Heart pacemaker	□Yes □No	Shingles	□Yes □No
Bruise easily	□Yes □No	Heart trouble/disease	□Yes □No	Sickle cell disease	□Yes □No
Cancer	□Yes □No	Hemophilia	□Yes □No	Sinus trouble	□Yes □No
Chemotherapy	□Yes □No	Hepatitis A	□Yes □No	Spina Bifida	□Yes □No
Chest pains	□Yes □No	Hepatitis B or C	□Yes □No	Stomach/Intestinal disease	□Yes □No
Cold sores/fever blisters	□Yes □No	Herpes	□Yes □No	Stroke	□Yes □No
Congenital heart disorder	□Yes □No	High blood pressure	□Yes □No	Swelling of limbs	□Yes □No
Convulsions	□Yes □No	Hives or rash	□Yes □No	Thyroid disease	□Yes □No
Cortisone medicine	□Yes □No	Hypoglycemia	□Yes □No	Tonsillitis	□Yes □No
Diabetes	□Yes □No	Irregular heartbeat	□Yes □No	Tuberculosis	□Yes □No
Drug addiction	□Yes □No	Kidney problems	□Yes □No	Tumors or Growths	□Yes □No
Easily winded	□Yes □No	Leukemia	□Yes □No	Ulcers	□Yes □No
Emphysema	□Yes □No	Liver disease	□Yes □No	Venereal Disease	□Yes □No
Epilepsy or seizures	□Yes □No	Low blood pressure	□Yes □No	Yellow Jaundice	□Yes □No

Please add any serious medical problems: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform **Gibbs Dentistry** of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____