gentech dentist

It's all about you.

*** ALL FIELDS MUST BE COMPLETELY FILLED OUT ****

PATIENT INFORMATION

last name, first name | age | d.o.b. (mm/dd/yyyy) | Male / Female

social security number | marital status | home phone # | cell phone #

parent / responsible party name | d.o.b. (mm/dd/yyyy)

home address | city | state | zip | driver's license #

email | employer | work phone #

emergency contact | phone #

How did you hear about Gentech? *Circle one & specify when applicable*

Internet
- ☐ Yelp
- ☐ Angie's List
- ☐ Facebook
- ☐ City Search
- ☐ YP.com
- ☐ Google Search
- ☐ Gentech Website
- ☐ Other _____

Mailer

Radio
Station: _____

Sign

Word of Mouth
Name of patient who referred you: _____

Insurance

Other
Please specify: _____ _____

Appt. Reminder Preference
- ☐ Text
- ☐ Email
- ☐ Phone

INSURANCE INFORMATION

Primary

insured name | employer | insurance company phone #

insurance company | insured ID | insured d.o.b. (mm/dd/yyyy) | patient relationship to insured

Secondary

insured name | employer | insurance company phone #

insurance company | insured ID | insured d.o.b. (mm/dd/yyyy) | patient relationship to insured

Health / Medical History

Are you allergic to any of the following? (circle all that apply)

Aspirin Penicillin Codeine Local Anesthetic Acrylic Metal Latex Sulfa Drugs Iodine Vicodin Other: _____

Pre-med: Do you normally take an antibiotic prior to dental treatment? Yes No

Do you have, or have you had, any of the following? (circle yes or no for each)

AIDS/HIV Positive	Yes	No	Diabetes	Yes	No	Hepatitis B or C	Yes	No	Rheumatic Fever	Yes	No
Alzheimer's Disease	Yes	No	Drug Addiction	Yes	No	Herpes	Yes	No	Rheumatism	Yes	No
Anaphylaxis	Yes	No	Easily Winded/Shortness of Breath	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Shingles	Yes	No
Angina	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Arthritis/Gout	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Heart Valve	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Artificial Joint	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Asthma	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Blood Transfusion	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Breathing Problem	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Chemotherapy	Yes	No	Heart Attack/Heart Failure	Yes	No	Pain in Jaw Joints	Yes	No	Ulcers	Yes	No
Chest Pains	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No	Sexually Transmitted Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Psychiatric Care	Yes	No	Yellow Jaundice	Yes	No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Radiation Treatments	Yes	No	Circulatory Problems	Yes	No
Convulsions	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No	Developmental Disorder	Yes	No
Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Renal Dialysis	Yes	No			

Have you ever had any serious illness not listed above? No Yes: _____

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

Signature of Patient (or Parent/Guardian) _____ Date _____

PATIENT NAME: _____

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Circle Yes or No:

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

The name, address, and phone number of your physician is: _____
name of physician

_____
street address city state zip physician phone #

Have you had any serious illness, operation or hospitalization? 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; including diet pills, prescription, non-prescription, vitamins, homeopathic or natural remedies? Yes No If yes, please list: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (ex. Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No Type, frequency, how long? _____

Do you use controlled substances? Yes No Type, frequency? _____

Do you drink alcoholic beverages on a regular basis? Yes No

Have you had any complications from previous dental treatment? Yes No If yes, please explain: _____

Have you had prolonged bleeding after dental extractions or cuts? Yes No If yes, please explain: _____

Do you have Obstructive Sleep Apnea or use a CPAP machine? Yes No

Do you have any other conditions, physical or mental limitations or disease you think the doctor should know about? Yes No If yes, please explain: _____

Women: Are you...

Pregnant / Trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (here or elsewhere)

☐ Cost ☐ No insurance ☐ Didn't hurt / Didn't think I needed treatment
☐ Fear of pain ☐ No time ☐ Other (please explain) _____

So that we can better assist you with your dental concerns, please list in order of importance what is essential to you: (1-3, 1 being most important)

_____ Health and preservation / keeping your teeth for life, eliminate disease
_____ Comfort and funtion / eating what you want to eat
_____ Esthetics / how your smile looks

Acknowledgement and Authorization

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of Gentech Dentist group responsible for any errors or omissions that I may have made in the completion of this form.

I understand that I am financially responsible for all charges whether paid by my insurance or not. I authorize my insurance company to pay to the dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that the dental group cannot render services on the assumption that any of the charges will be paid by an insurance company. I understand that a 1.5% monthly finance charge (18% annually) will be applied to all patient balances over 60 days old from the time of service.

Our office is staffed and prepared to provide you with your scheduled treatment. We understand that there will be cicurmstances that may require you to cancel your appointment. **If you cannot keep an appointment, we ask that you please provide us with 24-hour advance notice**. Missing more than two appointments without proper notification may lead to dismissal from our practice.

I understand that Gentech Dentist bills my insurance company as a courtesy and ultimately I am responsible for my (or the patient's) account balance, including unpaid charges, lack of coverage, pre-existing conditions, ineligibility, non-covered charges, or charges exceeding my (or the patient's) yearly maximum.

Payment is due in full at time of treatment unless prior arrangements have been made.

Signature of Patient (or Parent / Guardian) **Printed Name** **Date**

Reviewed by: _____ Date: _____

Doctor Signature: _____ Date: _____