GATE CITY DENTAL

Name: Home Phone: Cell Phone:

_____

Address: City: State: Zip:

_____

Email: Sex: Marital status: Date of Birth:

_____

Soc. Sec. # Who should we thank for referring you?

_____

In case of emergency, who should we contact? Phone:

_____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____Subscriber ID: _____

Policy holder: _____Relationship to Patient: _____

Policy holder birthdate: _____Soc. Sec. #: _____

Employer: _____ Business phone: _____

ADDITIONAL DENTAL INSURANCE:

Insurance Company: _____Subscriber ID: _____

Policy holder: _____Relationship to Patient: _____

Policy holder birthdate: _____Soc. Sec. #: _____

Employer: _____ Business phone: _____

DENTAL INFORMATION:

Former Dentist: _____ Date of Last X-Rays: _____

Date of Last Dental Visit: _____

Did you want to discuss a specific dental need today with the dentist? _____

Within the last **YEAR**, have you had:

Oral surgery yes___ no___
Discomfort in your jaw joint (TMJ/TMD) yes___ no___
Serious injury to the mouth or head yes___ no___
Do your gums bleed when you floss or brush? yes___ no___
Have you noticed any mouth odors or bad taste? yes___ no___

Are your teeth sensitive to hot/cold? yes___ no___
Do you clench or grind your teeth? yes___ no___
Do you have frequent headaches? yes___ no___
Do you have a Night Guard? yes___ no___ Are you wearing it? yes___ no___
Do you have any loose teeth or broken fillings? yes ___ no ___

How often do you floss? How often do you brush your teeth?
Do you use an electric toothbrush? Yes___ no___ Sonicare ___ Oral-B ___ Other___
If you use a manual toothbrush, what type of bristles do you use? Hard ___ Medium ___ Soft ___
Which toothpaste do you prefer? _____ Mouthwash? _____
Do you use other dental aids? Waterpik ___ AirFloss ___ Interdental brushes ___ Soft picks ___ Other___
Any homeopathic/natural dental products? If so, which ones? _____

MEDICAL INFORMATION:

ALLERGIES: To all yes responses please specify what you are allergic to:

Local anesthetics yes___ no___
Antibiotics yes___ no___
Hay fever/Seasonal yes___ no___
Sulfa Drugs yes___ no___
Metal yes___ no___
Aspirin yes___ no___
Latex yes ___ no ___
Codeine or other narcotics yes___ no___

_____

_____

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____
Date: _____

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actonel, Atelvia, Bonivia, Reclast, Prolia) for osteoporosis or Paget's disease? _____
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____

Name of physician or dentist making recommendation? _____

Women Only: Are you pregnant? ___ Are you nursing? ___
Are you using birth control pills or hormone replacement therapy? _____

Do you use controlled substances (drugs)? _____
Do you use tobacco (smoking, snuff, chew)? _____
Do you drink alcoholic beverages? _____

Are you under the care of a physician? _____Physician Name _____

Has there been any change in your health within the past year? _____ If yes, please explain:

_____

Are you taking any medications? _____ If yes, please list:

_____

_____

_____

Please check box to indicate whether you have had or have any of the following conditions. If necessary explain answers below.

AIDS/HIV☐	**Damaged Heart Valve**☐	**Kidney Problems**☐	**Stroke**☐
Anemia/Hemophilia☐	**Diabetes**☐	**Liver Disease**☐	**Thyroid Problems.**☐
Angina☐	**Eating Disorder**☐	**Low Blood Pressure**☐	**Tuberculosis**☐
Arteriosclerosis.☐	**Emphysema**☐	**Lupus**☐	**Ulcer**☐
Arthritis☐	**Endocarditis**☐	**Mitral Valve Prolapse**☐	**Weight loss/gain**☐
Artificial Heart Valves☐	**Epilepsy**☐	**Mental Disorder**☐	
Artificial Joints☐	**Fainting or Dizziness**☐	**Osteoporosis**☐	
Asthma/Bronchitis☐	**Gastrointestinal issues**☐	**Pacemaker**☐	
Autoimmune Disease☐	**Glaucoma**☐	**Radiation Treatment**☐	
Bleeding Abnormally☐	**Headaches/Migraines**☐	**Recurrent Infections**☐	
Blood Disease☐	**Heart Attack**☐	**Respiratory Disease.**☐	
Cancer/Chemotherapy☐	**Heart Murmur**☐	**Rheumatic Fever**☐	
Chemical Dependency☐	**Heart Disease**☐	**Seizure**☐	
Circulatory Problems☐	**Hepatitis.**☐	**Shortness of Breath.**☐	
Congenital Heart Defect☐	**High Blood Pressure**☐	**Sinus Trouble**☐	
Congestive Heart Failure☐	**High Cholesterol**☐	**Snoring/Sleep Apnea**☐	

_____

_____

_____

Do you have diabetes? If so what type _____

HbA1c # _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I hereby authorize payment directly to Gate City Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

_____

Signature of Patient/Legal Guardian **Date**