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___ Metal yes___ no___
Antibiotics yes___ no___ Aspirin yes___ no___
Hay fever/Seasonal yes___ no___ Latex yes ___ no ___
Sulfa Drugs 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.

What is your preference for receiving statements: _____ Paper (mailed) _____ Email _____Text

_____

Signature of Patient/Legal Guardian **Date**