Patient Registration Form
Gentle Care Dentistry & Implants
520-458-9460

Today's Date:	Preferred Pharmacy:
Name:	SS#:
Address:	Date of Birth:
How would you prefer us to contact you? Email/Text/Home or Work ph?	Cell #: Work #:
Home #:	Email:

How did you hear about us?

Google ____ Facebook ____ Patient:

Dental Insurance Information

Name of Insured:	Relationship to patient: self/spouse/child
Insured SS#:	Insured Date of Birth:
Insurance Company:	

Secondary Insurance Information

Name of Insured:	Relationship to patient: self/spouse/child
Insured SS#:	Insured Date of Birth:
Insurance Company:	

Dental Information

Do your gums bleed when you brush or floss? Y N	Do you have earaches or neck pain? Y N
Are your teeth sensitive to hot, cold, pressure or sweets? Y N (Circle all that apply)	Do you drink bottled or filtered water? Y N How often?
Is your mouth dry: Y N	Do you brux or grind your teeth? Y N
Have you had any periodontal (gum) treatments? Y N	Have you ever had orthodontic (braces) treatment? Y N
Do you have sores or ulcers in your mouth? Y N	Do you wear partials or dentures? Y N
Have you had any problems associated with previous dental treatment? Y N	Do you participate in recreational activities? Y N
Is your home water supply fluoridated? Y N	Do you have clicking, popping or discomfort in the jaw? Y N
Have you ever had a serious injury to your head or mouth? (Describe briefly if Y)	Are you currently experiencing dental pain or discomfort? Y N (Describe briefly if Y)

Women Only

Do you take birth control pills or hormone replacement therapy? Y N	Pregnant? How many weeks? Nursing?

Medical Information

Primary Care Physician: Phone #	Have there been any changes in your health in the 6 months? (Describe briefly, if Y)
Have you had a serious illness, operation or been hospitalized in the past 5 years? (Describe briefly, if Y)	Are you taking, or have you taken any diet drugs such as Pondinmin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phenterminecombination)? Y N
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? Y N Date began:	Are you taking or scheduled to begin taking either of the medications Fosamax (alendrontate) or Actonel (risendronate) for osteoporosis or Paget's disease? Y N
Do you use tobacco? Y N (If Y cigarettes/cigars/chew/snuff) Are you interested in quitting? Y N Maybe	Do you drink alcohol? Y N How many drinks per week?
Height: Weight:	

Allergies- circle all that apply

Local anesthetics	Metals
Aspirin	Latex (rubber)
Penicillin or other antibiotics	Iodine
Barbituates, sedatives or sleeping pills	Sulfa Drugs
Codeine or other narcotics	Seasonal, animal, food or other

Medications

Please list any medications including vitamins, natural, herbal or diet supplements and reasons why on Medication:

Medical Conditions-circle all that apply

Heart murmur	Anemia	Chest pain upon exertion	Contact Lenses
Mitral valve prolapse	Abnormal bleeding	Eating disorder	Kidney problems
Artificial heart valve	Rheumatic heart disease	Malnutrition	Night sweats
Rheumatic fever	Hemophilia	Gastrointestinal disease	Osteoporosis
Cardiovascular disease	Pacemaker	Ulcers	Systemic lupus erythemyatosus
Angina	Arthritis	Thyroid problems	G.E. Reflux/ Persistent heartburn
Arteriosclerosis	Autoimmune disease	Stroke	Persistent swollen glands in neck
Congestive heart failure	Rheumatoid arthritis	Glaucoma	Severe headache/migraine
Coronary artery disease	Asthma	Hepatitis, jaundice or liver disease	Diabetes Type I or II
Damaged heart valves	Bronchitis	Epilepsy	Excessive urination
Heart attack	Emphysema	Fainting spells or seizures	Chronic pain
Low blood pressure	Sinus trouble	COPD	Sexually transmitted disease
High blood pressure	Tuberculosis	Severe or rapid weight loss	AIDS or HIV infection
Congenital heart disease	Mental health disorder If Y, specify	Recurrent infections Type of infection:	Neurological disorders If Y, specify:
Blood transfusion If Y, date:	Cancer/Chemotherapy/Radiation treatment	Joint replacement Date and what:	Sleep related disorders

Signature_____ Date_____

HIPAA Privacy Form

Acknowledgment of receipt of Notice of Privacy Practices

This signed agreement acknowledges receipt of our Notice of Privacy Practices and documents our good faith effort to obtain that acknowledgment.
I have received a copy or explanation of this office's Notice of Privacy Practices.

_____ _____
Signature of Patient/Guardian Date

Prescription Consent

I consent for my pharmacy to disclose prescription medications.

_____ _____
Signature of Patient/Guardian Date

SMS and Email Consent

I authorize text messages and/or emails to be delivered to the following:
How would you prefer us to contact you? Email/Text/Both?

_____ _____
Signature of Patient/Guardian Date

A Word About Insurance

We appreciate your confidence in our office and are proud to welcome you as a new part of our dental family. We are finding that insurance companies are becoming less cooperative as time goes by. As a courtesy we will submit claims to your insurance and do all we can to cooperate with the requirements and requests made by your carrier. Please note that there are never any payment guarantees. There are times when insurance companies deny payment for treatment recommended by the dentist. If we are in network with your insurance, the fees we provide to you are based on their official fee schedule. Every insurance policy has certain restrictions, so please take the time to understand your specific plan. Also be aware there are many different policies within each insurance, even within employers specific plans offered. Your policy is an agreement between you and your insurance company and not between you and Dr. Hales. We know you have many choices for dentists here in town. We are glad you chose us!

_____ _____
Signature of Patient/Guardian Date