Gainesville Family Dentistry, PC

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About You

Today's Date: _____ E-Mail Address:_____
Name:_____ I Prefer To Be Called:_____
Male___ Female___ DOB: ___/___/_____ Age:_____ S.S.#_____-_____-_____
Mailing Address:_____
(circle one) Single Married Divorced Widowed Separated
Home#: _____ Cell#:_____ Work#:_____EXT:_____
Employer:_____
Employer Address:_____
How Long There?_____ Occupation:_____
Where and when are the best times to reach you?_____
Whom may we thank for referring you?_____
Other family members seen by us?_____
Previous /Present Dentist:_____
Last Visit Date:_____

Spouse Information

His/Her Name:_____ Employer:_____
Home#: _____ Cell#:_____ Work#:_____EXT:_____
Birthdate:____/____/_____ DL#:_____
Person Responsible for Account:_____ Relation:_____ SS#_____-_____-_____
Wk#:_____Ext:_____
Billing Address:_____

Primary Dental Insurance

Insurance Company Name:_____
Insurance Company Address:_____
Insurance Company Phone #:_____
Group #_____Ins ID#_____
Insured's Name:_____Relation:_____
Insured's Birth date:_____/_____/_____ Insured's Employer:_____
Insured SS#_____-_____-_____

Secondary Dental Insurance

Insurance Company Name:_____
Insurance Company Address:_____
Insurance Company Phone #:_____
Group #_____Ins ID#_____
Insured's Name:_____Relation:_____
Insured's Birth date:_____/_____/_____ Insured's Employer:_____
Insured SS#_____-_____-_____

Medical History

Do you have a personal physician? (circle one) Y N Physician's Name:_____
Phone#:_____Last visit date:_____

In the event of an emergency, is there someone who lives near you that we should contact?
His/Her Name:_____Relation:_____
Work #:_____Home#:_____

Your current physical history is: Good__Fair__Poor__
Are you currently under the care of a physician? (circle one) Y N
If yes, please Explain:_____
Are you taking any prescription/over-the counter drugs? (circle one) Y N
Please list each one:_____
Have you ever had any of the following diseases or medical problems?_____
Please circle one for each of the following:

Y N	Abnormal Bleeding	Y N	Herpes/Fever Blisters
Y N	Alcohol/Drug Abuse	Y N	High Blood Pressure
Y N	Anemia	Y N	HIV*/Aids
Y N	Arthritis	Y N	Hospitalized For Any Reason
Y N	Artificial Bones/Joints/Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Low Blood Pressure
Y N	Cancer/Chermotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Rheumatic Fever
Y N	Emphysema	Y N	Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sickle Cell Disease
Y N	Glaucoma	Y N	Sinus Problems
Y N	Hay Fever	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis
Y N	Heart Surgery	Y N	Ulcers
Y N	Hemophilia	Y N	Venereal Disease
Y N	Hepatitis		

Are you taking a Bone Building Drug? (circle one) Y N
Are you taking a Beta Blocker Drug? (circle one) Y N
Please list any medical conditions that you have ever had:_____

Are you allergic to any of the following? (circle one of each for the following)

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Tetracycline
Y N Penicillin
Y N Other

For Women: Are you taking birth control pills? (circle one) Y N
Are you pregnant? (circle one) Y N Week #_____
Are you nursing? (circle one) Y N

Please list any drugs/materials that you are allergic to:_____
Your current dental health is: Good_____Fair_____Poor_____
Do you like to smile? (circle one) Y N
Do your gums ever bleed? (circle one) Y N
How many times a week do you floss?_____
How many times a day do you brush?_____
Type of bristles? Hard_____Medium_____ Soft_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I need during diagnosis and treatment with my informed consent.
Payment is due in full at time of service unless prior arrangements have been approved.

Signature:_____
Date:_____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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For Office Use Only
I have reviewed the medical/dental information with the above patient named herein: Initials:____ Date:_____