Gentle Dental

290 Ferry Street, Suite B2, Newark NJ 07105 - Telephone: (973) 817-8888 - Fax: (973) 465-1955
www.getsmile.net

Today's Date: __________/____________/____________

PERSONAL INFORMATION

Patient's first and last name: ____

SSN:_______/_______/_______ Date of Birth: ______/______/_______ Gender: Male ☐ Female ☐

Address:____ Apt._____________

City: ___________________________________ State: _____________ Zip Code: _______________

Home Phone: ________/___________/____________ Cell Phone: _________/______________/___________

Employer:____________________________________ Work Phone: _________/______________/__________

E-mail: ____

Marital Status: Married ☐ Single ☐ Other ☐

Legal guardian name (If patient is under age of 18) :____

How did you hear about this office? TV ☐ Radio ☐ Print ☐ Internet ☐ Billboard ☐ Other ☐

DENTAL INSURANCE INFORMATION

Insurance company: ______________________________

Primary Insured's Name: ___________________________

Insured's SSN or ID #: ______________________________

D.O.B: ________/_________/__________

MEDICAL INSURANCE INFORMATION

Insurance company: ______________________________

Primary Insured's Name: ___________________________

Insured's SSN or ID #: ______________________________

D.O.B: ________/_________/__________

EMERGENCY CONTACT

In case of emergency, who should we contact?

Name: ____ Phone: _________/___________/___________

Relationship: ____

I understand that I am responsible to pay Gentle Dental for any treatment performed in this office, in case my insurance should neglect payment.
I understand that I am responsible for any outstanding balance. I will also take responsibility for any balances due to any collection agency. If any prosthodontics (Bridges, crowns, dentures) are not able to be completed due to patients missed appointments, the patient will be held responsible.
A fee of $50 will be charged to the patient's account if cancelation notice is not given 24 hours prior to the appointment.
I authorize Gentle Dental to submit dental claims to my Dental Insurance company in order to get pay for my dental treatment.

____ _________________________

Patient signature Date
or (Legal guardian if patient is under age of 18)

MEDICAL HISTORY

1. The name, address and phone number of my physician: ____________________

____

2. As far as you know, are you in good health? ____________________ **Yes** ☐ **No** ☐

Do you have, or have you had any of the following:

A. Rheumatic fever or rheumatic heart disease? ____________________ **Yes** ☐ **No** ☐
B. Congenital heart disease? ____________________ **Yes** ☐ **No** ☐
C. Cardiovascular disease (heart trouble, heart attack, high blood pressure, low blood pressure, arteriosclerosis, angina, stroke) ____________________ **Yes** ☐ **No** ☐
D. A Cardiac pacemaker ____________________ **Yes** ☐ **No** ☐
E. Sinus Trouble ____________________ **Yes** ☐ **No** ☐
F. Asthma, hey fever ____________________ **Yes** ☐ **No** ☐
G. Neurological disorder, example (Epilepsy, seizures, fainting) ____________________ **Yes** ☐ **No** ☐
H. Diabetes ____________________ **Yes** ☐ **No** ☐
I. Liver Disease, example (Hepatitis or Jaundice) ____________________ **Yes** ☐ **No** ☐
J. Arthritis ____________________ **Yes** ☐ **No** ☐
K. Stomach disease example (Ulcers) ____________________ **Yes** ☐ **No** ☐
L. Intestinal Disease example (Polyps) ____________________ **Yes** ☐ **No** ☐
M. Kidney Disease ____________________ **Yes** ☐ **No** ☐
N. Lung Disease example (Tuberculosis, Pneumonia) ____________________ **Yes** ☐ **No** ☐
O. Veneral disease ____________________ **Yes** ☐ **No** ☐
P. Blood disease example (Anemia) ____________________ **Yes** ☐ **No** ☐
Q. Is there someone in your family with diabetes? ____________________ **Yes** ☐ **No** ☐
R. Following and injury, do you bleed excessibly? ____________________ **Yes** ☐ **No** ☐

Yes ☐ **No** ☐
Yes ☐ **No** ☐
Yes ☐ **No** ☐

3. Have you been hospitalized for any serious condition? ____________________ **Yes** ☐ **No** ☐

If yes, for what? ____________________

4. Are you under the care of a physician? ____________________ **Yes** ☐ **No** ☐

Are you taking any of the other? ____________________ **Yes** ☐ **No** ☐

A. Antibiotics or Sulfa ____________________ **Yes** ☐ **No** ☐
B. Anticoagulants (blood thineers) ____________________ **Yes** ☐ **No** ☐
C. Medicine for high blood pressure ____________________ **Yes** ☐ **No** ☐
D. Steroids (cortisone) ____________________ **Yes** ☐ **No** ☐
E. Tranquilizers ____________________ **Yes** ☐ **No** ☐
F. Analgesics (pain killers, aspirin and codeine) ____________________ **Yes** ☐ **No** ☐
G. Antihistamines ____________________ **Yes** ☐ **No** ☐
H. Insulin, Orinase ____________________ **Yes** ☐ **No** ☐
I. Digitalis or drugs for hear trouble ____________________ **Yes** ☐ **No** ☐
J. Nitroglycerin ____________________ **Yes** ☐ **No** ☐
K. Sedatives (sleeping pills, barbiturates) ____________________ **Yes** ☐ **No** ☐
L. Any others ____________________ **Yes** ☐ **No** ☐

Yes ☐ **No** ☐
Yes ☐ **No** ☐

5. Are you allergic or have you had any allergic reaction to: ____________________ **Yes** ☐ **No** ☐

A. Local anesthetics ____________________ **Yes** ☐ **No** ☐
B. Penicillin or other antibiotics ____________________ **Yes** ☐ **No** ☐
C. Sulfas ____________________ **Yes** ☐ **No** ☐
D. Sedatives (sleeping pills, barbiturates) ____________________ **Yes** ☐ **No** ☐
E. Aspirin ____________________ **Yes** ☐ **No** ☐
F. Codeine or other narcotives ____________________ **Yes** ☐ **No** ☐
G. Any other allergic reactions? ____________________ **Yes** ☐ **No** ☐

Yes ☐ **No** ☐

6. Have you been exposed to radiation recently? ____________________ **Yes** ☐ **No** ☐

7. If FEMALE are you pregnant? How many months? ____________________ **Yes** ☐ **No** ☐

____________________ ____________________

Patient signature
or (Legal guardian if patient is under age of 18)

Date