Gentle Dental Care, Inc.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: Policy Holder Preferred Name:
Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Gentle Dental Care, Inc.

Center for Cosmetic Dentistry & Dental Medicine

111 Westview Boulevard
Spartanburg, SC 29306
(864) 582-3266
Fax (864) 583-3457

2400 N. Pleasantburg Dr.
Suite E
Greenville, SC 29609
(864) 235-4848
Fax (864) 331-8619

305 West Pine St.
Blacksburg, SC 29702
(864) 839-0034
Fax (864) 839-0064

DISCLOSURE OF MEDICAL INFORMATION

Patient Name(Print)_____SS#_____DOB_____
Address_____Phone_____
City, State, Zip _____

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We cannot discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	**Relationship of Patient**

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

Home:_____Work:_____Email_____

Cell phone:_____ Other: _____

Office may text message me at _____
If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office.

Name of person	**Phone Number**	**Relationship to Patient**

Messages: Appointment reminders or request for return calls may be left on the following answering machine or voice or email (circle all that apply)

At home At work On my cell phone E-mail Text to _____

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.
Patient/Personal Representative Signature: _____Date_____
Print Name of Personal Representative: _____
Relationship of Representative to Patient: _____

GDC Representative/Title:_____Date:_____

Note: This restriction applies only to care provided by the Gentle Dental Care, Inc. Either you or GDC may terminate this restriction by completing the following:

This agreement is terminated as of _____Signature_____

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(864) 839-0034
Fax (864) 839-0064

Financial Policy

Patient Full Name (Print) _____ DOB: _____

Please read this financial policy carefully, if you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by Gentle Dental Care Inc.

Payment for Service: Generally our office will inform you of the amount due when you check out. However, there are circumstances and/or treatments which require payment in advance. You will be advised of pre-payment amounts prior to your scheduled appointment. Pre-payment amounts will be collected prior to, or upon your arrival at the office for your appointment.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $30.00 service charge will be added on all checks returned to us for insufficient funds.

Non- Appointment Prescription Refills: A $15.00 charge per incidence will be added for non-appointment prescription refills.

Completion of Medical Forms: There will be a charge for forms such as disability, camp physicals, etc.

Copies of Medical Records: There will be a charge for completion of this process:

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $15.00
- Plus actual postage

Cancellation Policy: A fee of $25.00 for a follow up visit will be charged for all missed appointments not cancelled at least 24 hours prior to appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling the number listed above during normal office hours.

Delinquent Accounts: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at any of the above locations of which you are a patient, to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Signatures: I have read and understand these financial policies.

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name of Personal Representative: _____ Date: _____

Relationship of Representative to Patient: _____ Date: _____

GDC Representative: _____ Date: _____