Welcome To Advanced Gentle Dentistry Of Park Slope

Patient Information

Date_____ Home Phone_____ Cell Phone_____

Name_____Soc. Sec#_____
Last First Middle Initial

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address_____ City_____ State_____ Zip_____
Address and apartment #

Patient employed by_____ Occupation_____

Business Address _____ Business phone_____

E-mail address_____Whom may we thank for referring you?_____

In case of emergency who should we notify?_____Phone_____

Primary Dental Insurance

Person responsible for insurance account_____
Last Name First Name Middle initial

Relation to patient ☐ Self ☐ Spouse ☐ Other _____ Birth date_____ Soc. Sec. _____

Address (if different from patient's)_____Phone_____

City_____ State_____ Zip_____

Person responsible is employed by_____ Occupation_____

Business address_____ Business Phone_____

Insurance company _____

Contract #_____ Group#_____ Subscriber #_____

Secondary Dental Insurance

Person responsible for insurance account_____
Last Name First Name Middle initial

Relation to patient ☐ Self ☐ Spouse ☐ Other _____ Birth date_____ Soc. Sec. _____

Address (if different from patient's)_____Phone_____

City_____ State_____ Zip_____

Person responsible is employed by_____ Occupation_____

Business address_____ Business Phone_____

Insurance company _____

Contract #_____ Group#_____ Subscriber #_____

Dental History

Reason for today's visit_____

Other concerns you have about your teeth_____

Former dentist_____

Address_____

Date of Last dental Care_____ Date of last dental x-rays_____

How often do you brush? _____ How often do you floss?_____

Please check (☑) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot or cold
☐ Bleeding gums	☐ Loose teeth	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Broken fillings	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Periodontal treatment	☐ Sores or growth in your mouth

Dental Concerns

Please check (☑) if you are interested in any of the following:

☐ Braces ☐ Arch wire braces ☐ Invisible braces (Invisaline)

☐ Laminate Veneers to close spaces, align teeth, and provide permanent teeth whitening.

☐ Implants to replace missing teeth

☐ White fillings ☐ I understand that insurances do not pay for white fillings; I will pay the difference.

☐ Porcelain fillings (better and more expensive than white fillings)

☐ Good crowns (porcelain metal) affordable, durable and covered by all dental insurances

☐ Best crowns (metal free, or yellow gold porcelain combo) ☐ I will pay the difference that my insurance does not cover

☐ Laser gum therapy and application of arestin to help fight gum disease- new service not covered by insurance.

☐ Excellent lab work or ☐ The best lab work (that we use for celebrities and movie stars)

☐ Teeth whitening (bleaching) ☐ I would like to replace my mercury fillings with porcelain white fillings

☐ I am interested in Care Credit or Capital One to help me make small monthly payment for my dental needs

Medical History

Physician's Name_____ Physician's phone_____ Date of last visit_____

Have you had any serious illness or operation? ☐ Yes ☐ No if yes describe_____

Have you ever had a blood Transfusion? ☐ Yes ☐ No If yes give approximate dates_____

(Women) are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check (☑) if you have had problems with any of the following:

- ☐ Aids
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatment
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart Problems Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV positive
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Thyroid problems
- ☐ Tobacco habits
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease

MEDICATIONS
List medications you are currently taking

_____

_____

Allergies

_____

_____

Authorization

I Authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance

Signature_____Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office notice of privacy.

Signature_____ Please print name_____ Date_____

For office use only ☐ individual refused to sign ☐ communication barrier ☐ An emergency situation preventing us from obtaining acknowledgement ☐ Other (Please specify)_____