Welcome
TO OUR PRACTICE

Gentle Dental for the Entire Family

Bruce R. Schechter, D.D.S., L.L.C.
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Date_____

PATIENT INFORMATION:

Name _____Birthdate_____

Home Phone (_____)_____ Cell Phone (_____)_____ Email _____

Address _____City _____ State_____ Zip _____

Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Patient's or Parent's Employer _____ Work Phone (_____) _____

Business Address _____City _____ State_____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (_____) _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone (_____)_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (_____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (_____) _____

PRIMARY DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____)_____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Ins. Id. # _____ Group # _____

Address _____ City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE:

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____)_____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Ins. Id. # _____ Group # _____

Address _____ City _____ State _____ Zip _____

(Over)

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check ☑ if you have had any of the following:

❒ Bad breath. ❒ Grinding teeth ❒ Sensitivity to heat

❒ Bleeding gums ❒ Loose teeth or broken filings ❒ Sensitivity to sweets

❒ Clicking or popping jaw ❒ Periodontal treatment ❒ Sensitivity when biting

❒ Food collection between teeth ❒ Sensitivity to cold ❒ Sores or growths in your mouth

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

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❒ Yes ❒ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Thyroid Problems	Y N Cancer / Tumors	Y N Bleeding Problems
Y N Heart Surg. Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Radiation
Y N Hx of Endocarditis	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Shunts	Y N Respiratory Problems	Y N HIV + /AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N Glaucoma
Y N High/Low Blood Pressure	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Nervousness
Y N Jaw Problems TMJ/TMD	Y N Back Problems		

Please list all medications that you take and the reason: _____

_____

_____

Please list any surgeries or medical conditions you have or ever had: _____

_____

_____

Are you allergic to any of the following? ❒ Latex ❒ Penicillin / Amoxicillin ❒ Tetracycline ❒ Aspirin ❒ Motrin

❒ Dental Anesthetics ❒ Others: _____

Do you use tobacco? ❒ No ❒ Yes / How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ **FOR WOMEN:** Are you taking Birth Control Pills? ❒ Yes ❒ No

How many children have you had? _____ What are their ages? _____

Are you Pregnant? ❒ No ❒ Yes / How long? _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether of not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____ / _____/ _____

❒ Adult Patient ❒ Parent or Guardian ❒ Spouse

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

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