Gentle Dental Care

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Drs Harris, Obermiller, Luther | 1003 West 3rd Street - Grand Island, NE 68801-5831 (308)382-0110

Personal Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Is the patient a student? ◯ Yes ◯ No

Which doctor would you like to see?

☐No Preference ☐Dr. Kristine Harris ☐Dr. Jama Obermiller ☐Dr. Kristen Luther ☐Dr. Ryan Harris

Who may we thank for referring you to our office?

Name and phone number of another contact not living with you.

Insurance Information

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Responsible Party

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

*The person who signs this form is ultimately responsible for the account. Correspondence regarding this account will be directed to the person who is responsible for the account.

Patient Medical History

- ☐ AIDS/HIV
- ☐ Artificial Joints
- ☐ Cerebral palsy
- ☐ Cystic Fibrosis
- ☐ Erythromycin allergy
- ☐ Glaucoma
- ☐ Heart Bypass
- ☐ Hemophilia
- ☐ HPV
- ☐ Latex Allergy
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Penicillin Allergy
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sulfa Allergy
- ☐ Ulcers
- ☐ Amox Allergy
- ☐ Asthma
- ☐ Chemotherapy Tx's
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver Disease
- ☐ MVP
- ☐ Other
- ☐ Pine Nut Allergy
- ☐ Rheumatic Fever
- ☐ Special Needs
- ☐ Thyroid Problems
- ☐ Venereal Disease
- ☐ Anemia
- ☐ Blood Disease
- ☐ Clindamycin Allergy
- ☐ Dizziness
- ☐ Fainting
- ☐ Hearing impaired
- ☐ Heart Failure (CHF)
- ☐ High Blood Pressure
- ☐ Keflex Allergy
- ☐ Local Anest Allergy
- ☐ NeurologicalDisorder
- ☐ Pacemaker
- ☐ PRE-MEDICATE
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Mental Disorder
- ☐ NO EPI
- ☐ Parkinsons
- ☐ Radiation Treatment
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Tumors/Growths

If you checked any of the above conditions, please explain:

_____

_____

Physician _____

Are you under medical treatment now? ◯ Yes ◯ No

If yes, please explain.

_____

_____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ◯ Yes ◯ No

If yes, please explain.

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ◯ Yes ◯ No

Do you use tobacco or e-cigarettes? ◯ Yes ◯ No

Do you currently or have you in the past used controlled substances (drugs)? ◯ Yes ◯ No

Are you pregnant or think you may be pregnant? Are you nursing? ◯ Yes ◯ No

List any medications you are currently taking:

_____

_____

Please list any allergies you may have. (Medications, Latex, Metals, Etc.):

_____

_____

_____

Patient Dental History

Name of previous dentist and location:

_____

_____

Date of last exam: _____

Are you currently having any discomfort associated with your teeth? ◯ Yes ◯ No

Have you ever had difficulty with a dental visit? ◯ Yes ◯ No

Do you like your smile? ◯ Yes ◯ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I also authorize the dental staff to perform the necessary dental services that are needed for myself and/or for my dependent child.

Your signature will be required upon check out.

Response Date: ___/___/_____