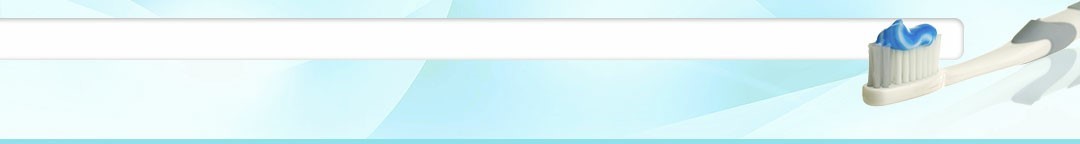
**Personal Information**



**Gentle Dental Northwest**

2504

N Webb Rd

•

Grand Island, NE 68803

**(308)381-7077**

info@gentledentalnwgi.com

**Chart#:**

**Patient Name:**

**Title:**

**Gender:**

**Family Status:**

FOR OFFICE USE ONLY

Last

First

MI

Preferred Name

Mr/Ms/Mrs/etc

Male

Female

Married

Single

Child

Other

**Birth Date:**

**SS#:**

\_\_\_-\_\_-\_\_\_\_

**Prev. Visit:**

**Email Address:**

**Best time to call:**

**Phone:**

Home

Mobile

Work

Ext

Fax

Other

**Address:**

**The following is for:**

Address 1

Address 2

City

State

\_\_\_\_\_-\_\_\_\_

Zip Code

the patient

the person responsible for payment

both

not applicable

**Employer Name:** **Phone:**

**Employer Address:**

**Is the patient a student?**

Address 1

Address 2

City

State

\_\_\_\_\_-\_\_\_\_

Zip Code

Yes

No

**Which doctor would you like to see?**

**Who may we thank for referring you to our office?**



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

No Preference

Dr Tressa Gloystein

Dr Kristen Luther



# Insurance Information

**Name:**

**Name of Insured:**

**Patient's relationship to insured:**

**Insurance Plan Name:**

**Name of Insured:**

**Patient's relationship to insured:**

**Insurance Plan Name:**

**Responsible Party**

**The following is for:**

**Title:**

**Gender:**

**Family Status:**

Last

First

MI

Self

Spouse

Child

Other

Last

First

MI

Self

Spouse

Child

Other

the patient's spouse

the person responsible for payment

both

neither-not applicable

Last

First

MI

Preferred Name

Mr/Ms/Mrs/etc

Male

Female

Married

Single

Child

Other

**Birth Date:**

**SS#:**

**DL#:**

**Email Address:**

**Best time to call:**

**Phone:**

\_\_\_-\_\_-\_\_\_\_

Home

Mobile

Work

Ext

Fax

Other

**Address:**

**The following is for:**

Address 1

Address 2

City

State

\_\_\_\_\_-\_\_\_\_

Zip Code

the patient

the person responsible for payment

both

not applicable

**Employer Name:** **Phone:**

City State

**Employer Address:**

Address 1

Address 2

\_\_\_\_\_-\_\_\_\_

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 Amox Allergy Anemia Arthritis

Artificial Joints Asthma Blood Disease Cancer

Cerebral palsy Chemotherapy Tx's Clindamycin Allergy Codeine Allergy

Cystic Fibrosis Diabetes Dizziness Epilepsy

Erythromycin allergy Excessive Bleeding Fainting Fibromyalgia

Glaucoma Head Injuries Hearing impaired Heart Attack

Heart Bypass Heart Disease Heart Failure (CHF) Heart Murmur

Hemophilia Hepatitis High Blood Pressure High Cholesterol

HPV Jaundice Keflex Allergy Kidney Disease

Latex Allergy Liver Disease Local Anest Allergy Mental Disorder

Multiple sclerosis MVP Neurological Disorder NO EPI

Osteoporosis Other Pacemaker Parkinsons

Penicillin Allergy PRE-MEDICATE Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Seasonal Allergies Sinus Problems

Special Needs Stomach Problems Stroke Sulfa Allergy

Thyroid Problems Tree Sap Allergy Tuberculosis Tumors/Growths

Ulcers Venereal Disease

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



**Physician**

**Are you under medical treatment now?​**

**If yes, please explain.**



**Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?**

**If yes, please explain.**



**Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?**

Yes

No

Yes

No

Yes

No

**Do you use tobacco or e-cigarettes?​** Yes No

Yes

Yes

No

**Do you currently or have you in the past used controlled substances drugs)?** No

**Are you pregnant or think you may be pregnant? Are you nursing?**

**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?**

**Have you ever had difficulty with a dental visit?**

8

/

5/2020

Yes

No

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:**