Jacksonville Gentle Dentistry

Patient Information

First Name_____ Last Name_____ D.O.B.___/___/___

Street Address:_____ APT #_____

City_____ State_____ Zip_____ Cell Phone_____

Email_____

Referred by: _____

Parent/Guardian/Responsible Party if Patient is under 18 years of age

First Name:_____ Last Name:_____ D.O.B.:___/___/___

Street Address (if different)_____ APT #:_____

City_____ State_____ Zip_____ Cell Phone:_____

Relationship to Patient:_____ Email_____

Insurance Information

Insurance Company Name: _____ Phone #:_____

Primary Insured Name: _____ DOB:_____ ID/SSN:_____

Acknowledgement and Authorization

I, the undersigned do hereby authorize and request for myself or the above named dependent, dental services and/or procedures deemed advisable by the Dentist for the diagnosis, care and treatment including taking x-rays, study models, photos, videos, diagnostic aides and administration of local anesthetic and/or pre-medications as may be necessary. I authorize release of any information concerning my or my dependent's dental care to any Specialist(s) or Dentist(s) referred to as may be necessary.

If using dental insurance to pay for my/my dependent's services, I do hereby authorize the Dentist/Practice to file my/my dependent's claim(s) with my insurance company. I authorize payment of the dental benefits directly to the Dentist and/or Practice and authorize release of any information needed by my insurance company for administering claims. I understand I'm responsible for the full cost of my/my dependent's care regardless of my insurance benefits. I understand and agree that any information provided to me by this office regarding my insurance benefits is an estimate based on the information received about my particular benefit contract, and not a guarantee of payment, coverage or benefits by my insurance.

I read and understand the above written in English. All information provided by me is true to the best of my knowledge.

x_____

Signature (Patient / Parent / Guardian / Responsible Party for patient) Printed Name Date

Dr. Signature:_____ Date:_____

Jacksonville Gentle Dentistry

Patient Dental History

Are you experiencing pain in any of the following areas? If YES, please indicate the type of pain and when it occurs:

☐ Upper front	☐ Lower front	☐ Throbbing/pulsating	☐ With Hot Drinks
☐ Upper right	☐ Lower right	☐ Dull ache but constant	☐ When chewing
☐ Upper left	☐ Lower left	☐ When drinking cold drinks	☐ When Brushing/Flossing

Do you have a family history of early tooth loss or periodontal or gum disease? ☐No ☐Yes

Have you ever been diagnosed with gum disease? ☐No ☐Yes

Were you able to complete your last dentist's recommendations? ☐No ☐Yes completed (MM/YY) _____

Do your gums bleed when you brush or floss? ☐No ☐Yes where?_____

Do you grind your teeth? ☐No ☐Yes

Do you have any pain when you clench your teeth? ☐No ☐Yes where? _____

Have you been diagnosed with having Sleep Apnea? ☐No ☐Yes If yes, do you wear a CPAP? ☐No ☐Yes

Do you smoke, use chewing tobacco, Vape, E-cigarettes? ☐No ☐Yes ____Packs per day _____Singles per day

Do you use any recreational drugs or narcotics? ☐No ☐Yes (please list)_____

Are you under the care of a Physician/Surgeon? ☐No ☐Yes Name:_____ Tel:_____

Are you under the care of a Psychologist/Psychiatrist? ☐No ☐Yes Name:_____ Tel:_____

Are you taking any medication(s)? ☐No ☐Yes (please list)_____

_____

Have you ever had or do you currently have fear of going to the dentist or had a negative experience at a dental office?

☐No ☐Yes If yes, please tell us what happened:_____

_____

Date of your last dental exam/cleaning?_____/_____/_____ Dentist's Name: _____ City/State _____

The above information is true to the best of my knowledge.

x_____

Signature (Patient / Parent / Guardian / Responsible Party for patient) Printed Name Date

Dr. Signature:_____ Date:_____

Jacksonville Gentle Dentistry

Patient Medical History

Date of your last physical exam:_____/_____/_____
Are you now or have you recently been under a physician's care? ☐No ☐Yes Reason: _____
Have you ever been a patient in a hospital or had any serious illness? ☐No ☐Yes Explain:_____

MEDICAL ALERTS:_____

HAVE YOU HAD, HAVE OR SUSPECTED HAVING ANY OF THE FOLLOWING?

☐No ☐Yes Arthritis	☐No ☐Yes Hepatitis: A, B or C	☐No ☐Yes Blood Transfusion
☐No ☐Yes Rheumatic Fever	☐No ☐Yes Jaundice	☐No ☐Yes Prolonged Bleeding
☐No ☐Yes Heart Trouble	☐No ☐Yes Liver Disease	☐No ☐Yes Fainting Tendency
☐No ☐Yes Heart Murmur	☐No ☐Yes Cancer or Tumor	☐No ☐Yes Epilepsy
☐No ☐Yes High/Low Blood Pressure	☐No ☐Yes Tuberculosis	☐No ☐Yes Thyroid Disease
☐No ☐Yes Chest Pain	☐No ☐Yes Diabetes	☐No ☐Yes Glaucoma
☐No ☐Yes Stroke	☐No ☐Yes Kidney/Bladder Trouble	☐No ☐Yes Radiation Treatment
☐No ☐Yes Shortness of Breath	☐No ☐Yes Anemia	☐No ☐Yes Mental Disorder
☐No ☐Yes Asthma or Hay Fever	☐No ☐Yes Lung Disease	☐No ☐Yes HIV or AIDS
☐No ☐Yes Sinus Trouble	☐No ☐Yes Blood Disease	☐No ☐Yes Prosthetic Joint Replacement

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU ARE TAKING OR HAVE TAKEN

☐No ☐Yes Cortisone Drugs	☐No ☐Yes Anticoagulants	☐No ☐Yes Tranquilizers
☐No ☐Yes Steroids	☐No ☐Yes Blood Thinners	☐No ☐Yes Sedatives

Are you taking any other medications? ☐No ☐Yes _____
_____

ARE YOU ALERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

☐No ☐Yes Penicillin	☐No ☐Yes Codeine	☐No ☐Yes Dental Anesthesia
☐No ☐Yes Aspirin	☐No ☐Yes Household Bleach	☐No ☐Yes Latex

Other_____

Have you traveled outside the United States in the last 90 days? ☐No ☐Yes (if YES where_____

Do you have or have you had any other disease or medical problems NOT listed on this form ☐No ☐Yes If YES, please explain_____

Women Only:

Are you Pregnant? ☐No ☐Yes (how many months? _____ Are you breast feeding ☐No ☐Yes
Are you presently taking medicines of any kind routinely (Birth control pills, shots or implant, hormone therapy, etc.)
☐No ☐Yes Explain:_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize my dentist to contact my physician(s). I will inform my dentist of any changes in my health and or medication. I will not hold my dentist or office staff responsible for any errors or omissions that I may have made in the completion of this form. The above information is true to the best of my knowledge and belief.

x_____
Signature (Patient / Parent / Guardian / Responsible Party for patient) Printed Name Date

Dr. Signature:_____ Date:_____

Jacksonville Gentle Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned have received a copy or read the explanation of this office's NOTICE OF PRIVACY PRACTICES written in plain language. I understand the Practice reserves the right to change the items of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this Practice to comply with laws. If changes to the Policy occur, this Practice will provide me a revised Notice of Privacy Practices upon my request.

In addition to our use of your health information for treatment, payment or healthcare operations, you may also give us written authorization to use your health information and/or to disclose it to anyone you list below for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Please be aware that once we disclose this information per your request to anyone you list below the information is subject to re-disclosure and may no longer be protected.

Other person(s) / Emergency Contact

Name _____ Phone #_____

Name _____ Phone #_____

Name _____ Phone #_____

Preferred Pharmacy:_____ Phone:_____

Address:_____ City _____ State _____ Zip _____

I authorize other healthcare providers to release protected medical information to my dentist and authorize the release of protected medical information to my referring doctors and specialists. I read and understand this form written in English. I authorize Doctors, Specialists and staff from this office to contact me and/or my dependent and/or anyone else I have listed above via mail, email, phone, voice mail and text about my/my dependent's dental and health information, treatment, payments, appointment confirmation, insurance and healthcare operations.

If Patient is a minor, please state your relationship to the patient: _____

x _____

Signature (Patient / Parent / Guardian / Responsible Party for patient) Printed Name Date

Jacksonville Gentle Dentistry

Patient Financial Agreement

We accept PPO, PDP and POS dental plans from major insurance companies. Sorry, we do not accept or file with Medical, Medicare, Medicaid, HMO or DMO plans and can only see patients with these plans as non-insured self-pay patients.

If you are using insurance to pay for your services, please know your insurance plan's coverage, limitations and restrictions. Please do not cancel your insurance until your outstanding claims have been paid.

I understand if I stop, cancel or postpone a treatment that I have already started, no refunds can be made to me for any treatment that involves a prescription for laboratory services such as: abutments, partials, dentures, crowns, implants, bridgework, Invisalign, retainers, nightguard, snore guard, sports guard or any surgical preparatory work.

I understand I am responsible for any balance due on my account and will promptly pay when billed or contacted by this office. Delinquent accounts over 90 days may get reported to credit bureaus and will accrue interest and collection costs including attorney fees and/or court costs.

x _____

Signature (Patient / Parent / Guardian / Responsible Party for patient) Printed Name Date

Dr. Signature: _____ Date: _____