PERSONAL INFORMATION

Patient_____ Preferred Name_____
First Middle Last

Gender: □ Male □ Female Are you: □ Married □ Single □ Other □ Child or Student

Date of Birth _____ Email Address_____

Mailing Address_____
Street No. City State Zip

Phone: Home:_____ Work:_____ Cell:_____ BEST # TO CALL: H/W/C Time: AM/PM

Preferred Method of Communication: □ Phone □ Text □ Email

Social Security No. (Required unless paying 100% cash upfront regardless of insurance benefits) _____

In case of an emergency, please list 2 contacts other than someone living with you, please include telephone # and relationship to you:

1)_____

2)_____

Names and ages of dependent children still living with you: _____

Have we treated any other family members? _____

Whom may we thank for referring you to our practice?
□ Dental Office □ Yellow Pages □ Internet □ Newspaper □ Work □ Insurance
□ Other: Please name _____

Spouse or Responsible Party Information **Name:**_____
The following is for: □ the patient's spouse □ the person responsible for payment □ neither – not applicable

Gender: □ Male □ Female Are you: □ Married □ Single □ Other □ Child or Student

Date of Birth _____ Email Address_____

Mailing Address_____
Street No. City State Zip

Phone: Home:_____ Work:_____ Cell:_____ BEST # TO CALL: H/W/C
Time: AM/PM

Social Security No. (Required unless paying 100% cash upfront regardless of insurance benefits) _____

Employment Information
The following is for: □ the patient □ the person responsible for payment

Employer Name:_____ Phone:_____

Address_____
Street No. City State Zip

I authorize treatment on the above named patient. I authorize the release of treatment information and I hereby assign any insurance benefits to Dr. Richard D. Gilmore, DMD. If monthly payments are necessary, I accept the terms and conditions as disclosed on the Financial Policy. Yes, I know that a credit report will be generated for any extension of credit.

_____ _____
Signature Date

MEDICAL HISTORY

Name of medical doctor _____ Phone_____

Date of last examination _____ Are you under a physicians care? □ Yes □No

Women Only:
Are you pregnant: □ Yes □ No If yes, what is your due date? _____

Are you on any blood thinners (Aspirin, Coumadin, Warfin, etc.) □ Yes □ No If yes, what is your INR/PT? _____

Do you take or have you taken Phen-Fen, Redux or Biophosphates? □ Yes □ No

Have you ever been told you need pre-med for dental treatment? □ Yes □ No

Are you on a special diet? □ Yes □ No

Have you ever been hospitalized or had a major operation? If yes, explain: _____

Do you use any tobacco products or drugs? If so, what?

_____

Medical Allergies (including seasonal allergies):

_____

Are you taking any medications or vitamins, please list:

_____

If yes, have you taken any of the following (check all that apply), they can cause major complications for extractions.
□ Fosamax □ Didronel □ Boniva □ Aredia □ Actonel □ Skelid (Taken by IV or orally?_____ Duration:_____)

Please check all that you currently have or have a history of: □ Latex Allergy □ Sulfa Allergy □ Penicillin Allergy

□ Aids/HIV Positive	□ Alzheimer's	□ Anaphylaxis	□ Anemia
□ Angina	□ Arthritis/Gout	□ Artificial Heart Valve	□ Artificial Joint
□ Asthma	□ Blood Disease	□ Blood Transfusion	□ Breathing Problems
□ Bruise Easily	□ Cancer	□ Chemotherapy	□ Chest Pain
□ Cortisone Medicine	□ Depression	□ Diabetes	□ Drug Addiction
□ Emphysema	□ Epilepsy or Seizures	□ Excessive Bleeding	□ Excessive Thirst
□ Fainting Spells/Dizziness	□ Frequent Cough	□ Frequent Headaches	□ Glaucoma
□ GERD	□ Hay Fever	□ Heart Attack/Failure	□ Heart Murmur
□ Heart Pace Maker	□ Heart Disease	□ Hepatitis A – B - C	□ High Blood Pressure
□ High Cholesterol	□ Hives or Rash	□ Intestinal Disease	□ Irregular Heartbeat
□ Kidney Problems	□ Leukemia	□ Liver Disease	□ Osteoporosis - Osteopenia
□ Mitral Valve Prolapse	□ Pain in Jaw Joints/TMJ	□ Parathyroid Disease	□ Radiation Treatment
□ Recent Weight Loss	□ Shingles	□ Sinus Trouble	□ Stomach Issues
□ Stroke	□ Swelling of Limbs	□ Thyroid Disease	□ Tonsillitis
□ Tuberculosis	□ Tumors or Growth	□ Ulcers	□ Yellow Jaundice

Do you have or have you had an illness not listed above? Please explain:_____

Is there anything you would like to discuss with the doctor in private: Yes – No

Blood pressure baseline: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medications change, I will inform the dentist at the next appointment without fail.

_____

Patient/Guardian Signature

Updated: _____ _____ _____ _____ _____ _____ _____ _____