Kenneth A. Gilbert DDS

Gentle Dental Care

Dental Registration and History

Confidential Patient Information

Today Date:

Patient' Name:

Sex: ☐ Male ☐ Female | Status: ☐ Married ☐ Single ☐ Child ☐ Other

Parent and/or Guardian's Name (if applicable):

Spouse's Name:

Social Security #: - - | Birth Date: / /

Phone (Home): (Work): ext:
(Cell):

(Fax): Best Contact:

Email Address:

Address:

_____
STREET

_____
CITY

STATE ZIP CODE

Employment Information

Employer Name: | Occupation:

Address:

_____
STREET CITY

STATE ZIP CODE

Referral Information

Whom may we thank for referring you to our practice?

Primary Dental Insurance Information

Who is financially responsible for this account?

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Insured: | Is insured a patient: ☐ Yes ☐ No

Insured's Birth Date: / / | Social Security #: - -

Group #:

Insured's Address:

_____
STREET

CITY STATE ZIP CODE

Insured's Employer:

Address:

_____
STREET

CITY STATE ZIP CODE

Insurance Plan Name:

Address:

STREET

CITY STATE ZIP CODE

Phone #:

Health Information

Date of Last Dental Visit: | Reason for this Visit:

Have you ever had any of the following? Please check all that apply

☐ AIDS	☐ Hay Fever	☐ Radiation Treatment	☐ Mitro Valve Prolapse
☐ Anemia	☐ Head Injuries	☐ Respiratory	☐ Birth Control
☐ Arthritis	☐ Heart Disease	Problems	Other:
☐ Artificial Joints	☐ Heart Murmur	☐ Rheumatic Fever	☐ _____
☐ Asthma	☐ Hepatitis	☐ Rheumatism	☐ _____
☐ Blood Disease	☐ High Blood Pressure	☐ Sinus Problems	☐ _____
☐ Cancer	☐ Jaundice	☐ Stomach Problems	☐ _____
☐ Diabetes	☐ Kidney Disease	☐ Stroke	☐ _____
☐ Dizziness	☐ Liver Disease	☐ Tuberculosis	
☐ Epilepsy	☐ Mental Disorders	☐ Tumors	DO YOU SMOKE OR U
☐ Excessive Bleeding	☐ Nervous Disorders	☐ Ulcers	OTHER TOBACCO
☐ Fainting	☐ Pace Maker	☐ Venereal Disease	PRODUCTS
☐ Glaucoma	☐ Pregnancy	☐ Codeine Allergy	☐ Yes
☐ Growths	Due Date:	☐ Penicillin Allergy	☐ No
		☐ Allergies	

Please list any medications you are currently taking:

Please list any weight loss medications you have taken or are currently taking

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:

Have you been admitted to a hospital or needed emergency care during the past years?
☐ Yes ☐ No
If yes, please explain:

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:

Name the physician:
Phone:

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date:__________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN