PATIENT REGISTRATION FORM

Welcome to GDC Smiles! To assist us in serving you, please complete the following confidential form. The information provided is important to properly registrar you as patient of our practice.

Today's Date _____/ _____/ _____

Patient's Name (complete) _____

Preferred Name: _____ **Gender: M**____ **F**____

Birth Date: Month: _____ Day: _____ Year: _____

Cell Phone #: _____ Home Phone #:_____

Email: _____

Street Address:_____ City_____ State _____ Zip_____

❑ Unmarried

❑ Married

Spouse's Name _____ Spouse's Phone #: _____

Emergency Contact _____ Relationship_____ Phone#_____

How did you find about us? _____

Name of the person who referred you to us: _____

We ask for the name of the referral source because we want to express our gratitude for his/her trust. Our office is committed to give all our patients the best customer service they can get. If for any reason you think we should improve in some areas please email to customerservice@gallodental.com with your concerns.

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑ NO insurance

❑ YES insurance - Insurance Company Name: _____

Please provide copy of your insurance card to our Insurance Specialist who will gladly assist you in collecting the necessary information.

Social Security #:_____ State License or ID #:_____
(Please provide copy of your ID to our front desk personnel)

Occupation:_____ Employer:_____

What days of the week do you prefer your dental appointments to be scheduled?: _____

Do you prefer communications on a form of (**check all that apply**):

***Please note that we will use your mailing address to send you statements of Unpaid balances and other necessary written communications.**

____ Phone Calls
____ Texts
____ Emails
____ Mail

Patient's Signature/Guardian: _____

MEDICAL HISTORY FORM ENG

PATIENT'S NAME: _____ **DOB**_____

Mark **Yes** or **No**

Do you have or have you had any of the following?:

Yes No -Artificial heart valve(s) / Stents
Yes No -Previous infective endocarditis
Yes No -Damaged heart valves
Yes No -Congenitally heart defect (CDH)
Yes No -Knee, joint, or hip replacement ****Date:**_____
Yes No -Chest pain upon exercise or angina
Yes No -Heart murmur
Yes No -Heart attack / Stroke
Yes No -Pacemaker
Yes No -Rheumatic fever / Rheumatic heart disease
Yes No -Cancer / Chemotherapy / Radiotherapy
Yes No -Tuberculosis
Yes No -Asthma
Yes No -Bronchitis / Emphysema / Sinus trouble
Yes No -High / Low blood pressure
Yes No -Kidney disease / Dialysis
Yes No -Hepatitis or other liver disease
Yes No -Diabetes I / II
Yes No -Sexual transmitted disease
Yes No -Epilepsy / Seizures / Fainting spells
Yes No -Emotional / Mental disorders
Yes No -AIDS or HIV positive
Yes No -Migraine or frequent headaches
Yes No -Blood transfusion ****Date:**_____
Yes No -Anemia / Other blood disorders
Yes No -Abnormal bleeding after surgery or trauma
Yes No -Thyroid problems
Yes No -Arthritis
Yes No -Fibromyalgia / Chronic pain syndrome
Yes No -G.E. Reflux / Persistent heartburn
Yes No -Eating disorder
Yes No -Sleep disorder

Do you smoke or use chewing tobacco? ❑YES ❑NO
If Yes, how many a day?_____ For how long?_____

History of alcohol or drug abuse? ❑YES ❑NO
If yes, for how long? _____ Have you been rehabilated? _____

Any family History of disease of the heart, kidney, liver, immune system, neurologic, high BP, stroke, cancer, diabetes. ❑YES ❑NO

Are you allergic to any of the following?

Yes No -Latex materials
Yes No -Penicillin
Yes No -Other antibiotics. Which one?_____
Yes No -Local anesthetics ("Novocain")
Yes No -Codeine or other narcotics
Yes No -Sulfa drugs
Yes No -Barbiturates, sedatives, or sleeping pills
Yes No -Aspirin
Yes No -Other:_____

During the past 12 months or at the present time, have you taken any of the following?

Yes No -Aspirin
Yes No -Anticoagulants (Plavix, Coumadin, etc)
Yes No -Antibiotics or Sulfa drugs
Yes No -High blood pressure medicine
Yes No -Antidepressants or Tranquilizers
Yes No -Insulin, Orinase, or other diabetes drugs
Yes No -Digitalis (e.g, Digoxin) for Cardiovascular disease
Yes No -Nitroglycerin
Yes No -Cortisone or other steroids
Yes No -Osteoporosis Medicine (bisphosphonates-e.g, Fosamax)
Yes No -Nonprescription drug/supplements
Yes No -Other. **List:** _____

Have you taken in the past five years any of the following?

Yes No -Cortisone or other steroids
Yes No -Osteoporosis Medicine (bisphosphonates-e.g, Fosamax)

HEIGHT_____ **WEIGHT**_____

ONLY FOR WOMEN:

Yes No -Are you pregnant?. Weeks?: _____
Yes No -Are you nursing?
Yes No -Taking hormones or contraceptives?

❑YES ❑NO Do you think you're a healthy person with a Good General Condition?
❑YES ❑NO Have you been hospitalized or had surgery in the past three years?. Why? _____
❑YES ❑NO Do you have other condition/s not listed above that we should know? Which?: _____
❑YES ❑NO Do you have a regular physician? Provide his/her Name:_____ Ph #:_____

I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful heath history and that the dentist and his/her staff will rely on this information for treating my child or me. I acknowledge that my questions about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors of omissions that I may have made in the completion of this form. I understand that I am fully responsible to communicate any changes regarding the medical condition of my child or mine during future dental visits.

_____ _____ _____
PATIENT'S SIGNATURE / GUARDIAN of Minor **Relationship with patient** **DATE**

For completion by the dentist.

ASA PS Classification: _____ **Medical Consult Needed?:** ❑YES ❑NO **BP**: _____ **Pulse**: _____

Comments: _____

DENTIST'S SIGNATURE _____

PATIENT DENTAL HISTORY

ENG

PATIENT'S NAME _____ **DATE OF BIRTH** _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED YES NO

	YES	NO
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do any of your teeth feel painful	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you experienced any of the following problems		
Clicking in your jaw	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your jaw	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Have you ever worn a bite plate or other appliance	☐	☐
Have you had any difficult extractions in the past	☐	☐
**Have you ever had any prolonged bleeding following Extractions	☐	☐
**Do you wear dentures or partials	☐	☐
If yes, give the date they were placed _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

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 MY CHILD OR ME 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 GALLO DENTAL CARE, LLC OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE SOLE RESPONSIBLE FOR THE FINAL PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____ _____

PATIENT'S SIGNATURE / GUARDIAN OF MINOR **RELATIONSHIP WITH PATIENT** **DATE**

_____ _____

DENTIST'S SIGNATURE **DATE**

DENTIST'S COMMENTS: _____