Patient Dental Assessment Form

Name: _____ Date: _____

To aid in our diagnosis and your treatment, please take a moment and answer the following questions.
Please check your response.

Esthetic Concerns

Do you dislike the color of your teeth?	__Yes __No
Do you have spaces between your teeth?	__Yes __No
Do you have dark fillings, that show when you smile?	__Yes __No
Are your teeth crowded or crooked?	__Yes __No
Do you have existing crowns or dental work that you consider "ugly"?	__Yes __No
Are you self-conscious of your teeth and/or smile?	__Yes __No
Do you avoid smiling when you have your picture taken?	__Yes __No
Would you like to improve your existing smile?	__Yes __No

Sleep Apnea Concerns

Do you snore while asleep?	__Yes __No
Has a family member/friend/etc. ever told you that you snore?	__Yes __No
Do you experience lack of energy or daytime drowsiness?	__Yes __NO

Bruxism concerns (Teeth Grinding)

Do you wake up with a sore jaw, dull headache, or tooth pain?	__Yes __No
Has anyone told you that you are making a grinding sound at night?	__Yes __No
Do you have swelling of the lower side of your jaw?	__Yes __No

Place a checkmark next to which of the following are concerns you have regarding dental treatment:

___ Fear of treatment

___ Time of treatment concerns

___ Financial Concerns

___ Distance to office

___ Not understanding treatment

Gentle Dental Care

www.texasgentledental.com

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____ DL# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthday _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relation to patient _____

Insurance Co _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthday _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage

With _____ and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature **Date**

_____

Relationship

3 PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell Phone _____

Best time and place to reach you _____ Email Add. _____

IN CASE OF EMERGENCY, CONTACT (*specify someone who does not live in your household*)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had the following:

Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blisters in lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarettes, pipe, or Cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

—OVER—

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Aids	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting or Dizziness	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Joint	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Hepatitis, Type _____	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Bleeding abnormally, with			Herpes	❑ Yes	❑ No	Skin Rash	❑ Yes	❑ No
Extractions or surgery	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Swelling of Feet	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	or Ankles	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Swollen Neck Glan	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tonsilitis	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Mitral Valve Problems	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Cough, persistant or			Nervous Problems	❑ Yes	❑ No	Tumor or growth on		
bloody	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	head or neck	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Women:			Ulcer	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Are you pregnant?	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Do you wear contact	❑ Yes	❑ No	Due date_____			Weight Loss Unexplained?	❑ Yes	❑ No
Lenses?			Are you nursing?	❑ Yes	❑ No			

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping Pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other_____

Patients Signature_____ Date_____

6 UPDATES

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For What conditions?_____

Are you taking any new medications?_____ If so what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions?_____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Gentle Dental Care

FINANCIAL RESPONSIBILITY STATEMENT

Patient Name _____

Responsible Party_____

Relationship to Patient_____

Billing address_____

Street address apt# City State Zip

Phone numbers _____

Home # Work# Cell#

License# _____ SS#_____

Financial Policy:

- Payment in full is expected at the time of treatment.
- Patients with dental insurance are expected to pay their estimated co-pay at the time of treatment.
- VISA, MASTER CARD, AMERICNA EXPRESS, AND DISCOVER Credit Cards are accepted.
- Checks are accepted upon approval through Global Finance (No temporary checks) you must have a current picture ID.
- Long term financing is available through CareCredit, upon completion of a credit application and approval.
- Balances over 90 days old are charged an 18% APR service monthly charge.
- We reserve the right to charge for appointments cancelled or not kept without a 24 hour notice. The fee is $25 per appointment, lengthy appointments are higher.

***To our patients with Dental Benefits:**

Dental Plan Name _____ Group# _____

It is our pleasure to help you file your insurance claim forms or take assignment on your dental benefits as designed by the Dental Plan indicated above. We provide this service at no additional cost to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the plan sponsor determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this agreement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the plan sponsor.

_____ _____

Signature of Responsible Party Date

Gentle Dental Care

Broken Appointment Policy

Reservation Fee of Treatment Policy

Broken Appointment Policy

Due to increasing number of broken appointments at our office, it is necessary to enforce a Broken Appointment Policy effective January 1, 2015.

Every effort is made to contact patients before their appointment to confirm, either by phone, email, or text message.

Please understand that this is a courtesy reminder only. **DO NOT DEPEND ON THIS.** If we are unable to reach you, your appointment card will serve as your confirmation of the appointment and implies your obligation to be present.

We require that you notify us of any cancellation at least 24 hours prior to your office appointment, so that we may give your allocated time to another patient in need of dental care. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule for the next available time.

The first incident of a missed appointment without 24 hour notice will be documented and the broken fee will be waived. If, however, a second appointment is missed without 24 hour notification a $25 fee will be applied to your account. If 3 broken appointments occur, our office reserves the right to review your account. We will decide if any subsequent appointments will be made or placed on a walk in basis. The fee must be paid before the appointment is scheduled.

An appointment is considered to be broken if the following occur:

- The patient fails to appear for the appointment
- The patient appears more than 15 minutes late for scheduled appointment
- The patient cancels or reschedules with less than a 24 hour notice

Reservation Fee for Treatment

A $50.00 reservation fee may be collected for treatment, at the time the appointment is being scheduled. This applies to treatment one hour or longer. This fee will be credited towards your treatment unless you fail to show up.

I, _____ have read and understand the above mentioned policy.

_____ _____

Patient Signature (parent or guardian if minor) Date