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We will provide appointment reminders and appointment related information to your Email address listed below:

Date: _____

Patient Email: _____

Please complete and return this form to the Front Desk on the day of your appointment (or you may mail, fax or email this form to our office prior to your appointment). Please bring in all insurance Forms and Insurance Cards.

PATIENT INFORMATION

Patient's Name (First, Middle, Last):			<input type="checkbox"/> Male	<input type="checkbox"/> Female
I prefer to be called by the name:				
Patient's Address:				
City, State:			Zip:	
Date of Birth:	Age:	Soc. Sec. No.:		
Home Phone:	Work Phone:	Cell/Pager:		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Retired <input type="checkbox"/> Other
Employer:				
Employer's Address (Street):				
City, State:			Zip:	
Occupation:				
(indicate if full time student and name of school):				
City, State:				

FILL IN FOR SPOUSE/OTHER

Spouse/Partner Name:	
Is Spouse:	Actively Employed <input type="checkbox"/> Retired <input type="checkbox"/>
Employer:	Employer's Phone:
Employer's Address:	
City, State:	Zip:

FILL IN IF PATIENT IS A MINOR

Parent 1 / Guardian (First, Middle, Last):	
Employer:	Employer's Phone:
Employer's Address:	
City, State:	Zip:
Parent 2 / Guardian (First, Middle, Last):	
Employer:	Employer's Phone:
Employer's Address:	
City, State:	Zip:

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name:	
Insurance Co. Address:	
Insurance Co. Phone #:	
Group # (Plan, Local or Policy #):	
Subscriber's Name:	Relationship:
Subscriber's Birthdate:	Subscriber's # or assigned ID #:
Subscriber's Employer or Company Name:	

Secondary Dental Insurance

Insurance Co. Name:	
Insurance Co. Address:	
Insurance Co. Phone #:	
Group # (Plan, Local or Policy #):	
Subscriber's Name:	Relationship:
Subscriber's Birthdate:	Subscriber's # or assigned ID #:
Subscriber's Employer or Company Name:	

REFERRAL SOURCE

Whom may we thank for referring you to our office:		
Name:		
Address:		
Relationship:		
In the event of an emergency, is there someone who lives near you that we should contact?		
His / Her Name:		Relationship:
Address:		
Wk #:	Hm #:	Cell #:

***Please complete Patient Medical/Dental History on reverse side.**

LAST NAME _____ FIRST NAME _____

Preferred Name: _____

Medical Health History and Dental Health History to be completed by patient:

MEDICAL HEALTH HISTORY

General health (Please check): excellent good fair poor

Who is your physician?

Address _____ Phone # _____

When was your last complete physical examination?

Have you ever had any of the following medical conditions or problems?

- | | | | |
|------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|------------------------------------|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Clotting/Bleeding problems | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Thyroid conditions | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Rheumatic/Scarlet fever | |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Respiratory disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hearing impairment | |
| | | <input type="checkbox"/> Latex Allergy | |

Do you have any drug allergies or an adverse reaction to any medications? Y N
If so, what? _____

Are you taking medications? Y N If so, what? _____

Are you being treated for anything now? Y N

WOMEN: Are you or might you be pregnant? Y N
Are you presently taking birth control pills? Y N

Tobacco Use History (smoke &/or chew) Type used: Y N
 Never Occasionally Steady Use Dates of use:
Have you tried Quitting? Yes No

DENTAL HEALTH HISTORY

When was your last dental appointment?	Do you clench or grind your teeth frequently?
What treatment did you last receive?	Are you happy with the appearance of your teeth?
When were your last dental x-rays taken?	How do you rate your smile on a scale of 1-10? (10 being the best)
Have you ever responded adversely to dental treatment?	How important is your smile on a scale of 1-10? (10 being the best)
Are any teeth painful to cold, sweets, pressure?	Are you a person who 'guards your smile' because you're not comfortable with the appearance of your teeth?
Do your gums bleed when you brush your teeth?	

Please list any concerns or questions:

This column for office use only:

Medical History Update

Date _____ /By: _____

Pre-Medication: _____

Any Changes? _____

If so, what? _____

Medications? _____

If so, what? _____

Signature _____

Date _____ /By: _____

Pre-Medication: _____

Any Changes? _____

If so, what? _____

Medications? _____

If so, what? _____

Signature _____

Date _____ /By: _____

Pre-Medication: _____

Any Changes? _____

If so, what? _____

Medications? _____

If so, what? _____

Signature _____

Date _____ /By: _____

Pre-Medication: _____

Any Changes? _____

If so, what? _____

Medications? _____

If so, what? _____

Signature _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I agree to be responsible for payment of all services rendered by this office. Should I have any dental insurance benefits, I further agree: To authorize the release of any medical and dental information necessary in order to process any insurance benefits for all professional services rendered. I also authorize the assignment of any insurance benefits to the office of Richard C. Gillis, D.M.D., P.C. I have received a copy of this office's Notice of Privacy Practices. By signing this form, you will consent for our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

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Patient Signature

Date