Gentle Touch FAMILY DENTISTRY

67 Smithfield Blvd.
Plattsburgh, NY 12901
P: (518) 324-5555 F: (518) 324-5898
www.gentletouchfamilydentistry.com

Medical Alert for Office Use

THANK YOU for visiting Gentle Touch Family Dentistry! It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. Please help us by completing this form.

PATIENT INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET CITY STATE ZIP

Social Security # _____ Birth Date _____ Emergency Contact _____

Gender ❑ Female ❑ Male Married ❑ Yes ❑ No Emergency Phone _____

Home Phone _____

Work Phone _____

Mobile Phone _____

Email Address _____

By providing my email address, I hereby give permission to Gentle Touch Family Dentistry, Dr. Szmigiel and staff, to communicate electronically with me via emails and/or text messages. I am aware and accept the possible risks of receiving electronic information using unencrypted e-mails and text messages.

BY PROVIDING MY CONTACT INFORMATION ABOVE, I AUTHORIZE THIS OFFICE TO COMMUNICATE WITH ME ABOUT MY HEALTH, TREATMENT PLAN, BILLING, AND FINANCIAL OPTIONS.

Check Preferred Contact Method(s): ❑ Home Phone ❑ Work Phone ❑ Mobile Phone ❑ Email

Please send me appointment reminders by (choose one): ❑ Email ❑ Mail

DISCLOSURE OF YOUR HEALTH INFORMATION

Please list any other parties who can have access to your health information. (Disclosure to other parties includes: spouse, children, step parents, grandparents and any care takers who can have access to your records)

Print name: _____ Relationship: _____

Print name: _____ Relationship: _____

INSURANCE INFORMATION

Subscriber Name _____ Insurance Name _____

Relation to Patient ❑ Self ❑ Spouse ❑ Child Insurance Address _____

Employer _____ Insurance Phone # _____

Social Security # _____ DOB _____ Group # _____ ID# _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GENTLE TOUCH FAMILY DENTISTRY OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF THE DENTAL TREATMENT.

THE UNDERSIGNED ACKNOWLEDGES RECEIPT OF A COPY OF THE CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES FOR THIS HEALTHCARE FACILITY.

Signature _____ Date _____

IF PATIENT UNDER 18

Responsible Party (print name) _____ Relation to Patient _____

Address (if different than patient) _____
STREET CITY STATE ZIP

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OTHER INFORMATION

How did you hear about us? ❑ From another patient ❑ Website ❑ Yellow Pages ❑ Newspaper ❑ Billboard

_____

(If someone referred you here, please write down their name so we can thank them)

What was the reason for today's visit? _____

When was your last dental and hygiene appointment? _____

Have you ever been told that you have or have you been treated for gum disease? _____

Have you ever noticed your gums bleeding? _____

Do you love your smile? _____ Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like ***most*** about your last dentist? _____

Level of fear coming to the dentist?

1	2	3	4	5	6	7	8	9	10
Least Fearful									Extremely Fearful

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PATIENT MEDICAL HISTORY

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Bell's Palsy
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Pain
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Jaw Pain/Cracking Noise (TMJ)
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Postural Problems
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other _____

_____

Y	N	
❑	❑	Do you Smoke or use Tobacco?
❑	❑	Would you like information about the NYS Quitline?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If yes, # of weeks
❑	❑	Are you nursing?

Please list all medications that you are currently taking: ❑ None _____

_____

_____

_____

Is there any disease, condition or problem that you have but not covered above? _____

_____

_____

I certify to the above statements regarding my medical condition. It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

_____ _____

Parent/Guardian's Signature Date