



Timothy E. Gillespie, DMD, FAGD
COSMETIC, GENERAL & IMPLANT DENTISTRY

WELCOME to our practice! Our goal is to provide the very best possible dental care for you so you may achieve optimal dental health throughout your lifetime.

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PATIENT	PAYMENT RESPONSIBILITY	
Patient's Name _____	Name _____	
Preferred Name _____	Relationship to Patient _____	
Address _____	Address _____	
City, State _____ Zip _____	City, State _____ Zip _____	
Circle Best # to confirm appointment:	Home Phone _____ Cell/Pager _____	
Home Phone _____ Cell/Pager _____	Work Phone _____ Ext _____	
Work Phone _____ Ext _____	Social Security # _____ Birthdate _____	
E-Mail _____	Employer _____	
Birthdate _____ Marital Status _____	Occupation _____ How Long _____	
Social Security # _____ Gender _____	PERSON TO CALL IN AN EMERGENCY	
Employer _____	Name _____	
Occupation _____ How Long _____	Phone # _____ (h) _____ (w)	
College Student _____ Y _____ N	Cell # _____	
If so, Name of College _____		
Fulltime _____ Y _____ N		
SPOUSE'S INFORMATION		
Name _____		
Employer _____		
Work Phone # _____ Ext _____		

PRIMARY DENTAL INSURANCE	ADDITIONAL DENTAL INSURANCE
Policyholder's Name _____	Policyholder's Name _____
Policyholder's Address _____	Policyholder's Address _____
Relationship to Patient _____ Policyholder's Birthdate _____	Relationship to Patient _____ Policyholder's Birthdate _____
Policyholder's Soc. Sec. # _____	Policyholder's Soc. Sec. # _____
Policyholder's Employer _____	Policyholder's Employer _____
Insurance Company Name _____	Insurance Company Name _____

AUTHORIZATION AND RELEASE
<p>I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered on my behalf or my dependents' during the period of such dental care to third party payors and/or health practitioners.</p> <p>Authorization To Pay Benefits To Dentist: I hereby authorize payment directly to Timothy E. Gillespie, D.M.D., P.A., of the Dental Benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have received or read "Notice of Privacy Practices" for this office. (Also located in each treatment room and available on request.)</p> <p>PATIENT'S SIGNATURE _____</p> <p>SIGNATURE OF PARENT/GUARDIAN (if minor) _____ DATE _____</p>

MEDICAL/HEALTH HISTORY UPDATE

Your overall health, as well as any medications that you take, could have an important interrelationship with the dental care you receive. Do you have, or have you ever had, any of the following? Please check.

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Codeine	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Penicillin	What type _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Panic Disorder
What type _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder	Due Date _____
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Premed with antibiotic for
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bulimia	cleaning or treatment
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Emphysema	Type of antibiotic _____
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Epilepsy or Seizures	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting	<input type="checkbox"/> Psychiatric Treatment
What type _____	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Chest Pain	<input type="checkbox"/> Sinus Problems
Date of last treatment _____	<input type="checkbox"/> Heart Disease or Condition	<input type="checkbox"/> Smoker
<input type="checkbox"/> Radiation	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Smokeless Tobacco
Date of last treatment _____	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stomach or Digestive Disorder
<input type="checkbox"/> Connective Tissue Disorder	<input type="checkbox"/> Pacemaker	What type _____
What type _____	<input type="checkbox"/> Shunt	<input type="checkbox"/> Stroke
<input type="checkbox"/> Coumadin or Other Blood Thinners	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tumor History
<input type="checkbox"/> Type I	<input type="checkbox"/> HIV Virus/AIDS	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Type II	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stomach
<input type="checkbox"/> Drug Allergy or Sensitivity	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Mouth
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Hip	<input type="checkbox"/> STD
<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Knee	
	<input type="checkbox"/> Other _____	
	Date of Surgery _____	

Are you allergic or sensitive to penicillin or ANY other drugs or medicine? Please list: _____

Do you have any disease, condition or problem not listed above? If yes, please explain: _____

Hospitalization and Surgery - Explain: _____

Name of your family physician _____ City/State/Phone _____

Are you under the care of a physician now? Yes No Reason _____

Have you taken any drugs or medications in the past year? _____ If so, list: _____

Please list your current medications, including herbs or vitamins!

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DENTAL HISTORY

Do you have any dental implants? _____	circle	YES	NO
Are you aware of any dental problems today requiring our immediate attention? _____	YES	NO	
When was your last dental visit? _____ What was done? _____			
Do your gums bleed when brushing or flossing? _____	YES	NO	
Are you apprehensive about receiving any dental treatment? _____	YES	NO	
Have there been any complications during previous dental treatment? _____	YES	NO	
Have you had abnormal bleeding associated with extractions, surgery or trauma? _____	YES	NO	
Have you ever been referred to a periodontist? _____	YES	NO	
Do you have chronic headaches, neck or shoulder pain? _____	YES	NO	
Do you clench or grind your teeth while awake or during sleep? _____	YES	NO	
Do your jaws grind, pop, click or lock open when your mouth is open wide? _____	YES	NO	
Are your teeth sensitive to (underline if yes) heat, cold, sweets or biting pressure? _____	YES	NO	
Are you unhappy with your teeth and their appearance? _____	YES	NO	
Thank you for your help. If there is any information that you feel might be of value to us in your treatment, please explain:			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR) _____ DATE _____