



Drs. Gillespie and Martin, P.A.
C O S M E T I C & G E N E R A L D E N T I S T R Y

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 _____	
Birthdate _____ Marital Status _____	Employer _____	
Social Security # _____ Gender _____	Occupation _____ How Long _____	
Employer _____	PERSON TO CALL IN AN EMERGENCY	
Occupation _____ How Long _____	Name _____	
College Student <input type="checkbox"/> Y <input type="checkbox"/> N	Phone # _____ (h) _____ (w)	
Name of College _____	Cell # _____	
Fulltime <input type="checkbox"/> Y <input type="checkbox"/> 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 Drs. Gillespie & Martin, 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. A credit report may be obtained according to services provided. 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"/> Mitral Valve Prolapse | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Disease or Condition | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hepatitis A, B, C or D |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bulimia | <input type="checkbox"/> HIV Virus/AIDS |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease or Trouble | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Smoker or Tobacco user (Smokeless) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Joint (Hip/Knee) Replacement | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Frequent Chest Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Tumor History | <input type="checkbox"/> Due Date |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mouth | <input type="checkbox"/> Date of Last Treatment | |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stomach/Digestive Disorders | | |
| <input type="checkbox"/> Diabetes | | | |

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? _____

Are you taking medication, drugs, herbs or vitamins? If yes, please list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

DENTAL HISTORY

circle

- Do you have any dental implants? _____ 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 _____