GENTLE HANDS DENTAL CARE
PATIENT REGISTRATON AND MEDICAL HISTORY

Date:___/___/___ (PLEASE PRINT) Preferred contact: ❑Text ❑ Email ❑Cell ❑Home Phone

PATIENT INFORMATION Any overseas travel recently? ❑ Y ❑ N

Name_____ Single Married Other SSN_____/____/_____
Last Name First Name Initial Preferred Name (Please circle one)

Cell Phone:_____ Home Phone:_____ Email_____ Birthdate: ___/___/_____

Street Address_____ City_____ State_____ ZIP_____

Employer Name_____ Phone:_____

Business Address_____ City_____ State_____ ZIP_____

Whom may we thank for referring you? Friend/Relative (Name:_____) Insurance List Ad Website Other:_____

In case of emergency, who should be notified? Name:_____ Phone: _____ Email:_____

FINANCIALLY RESPONSIBLE PARTY INFORMATION (if different from above)

Name_____ Email:_____
Last Name First Name Initial Preferred Name

Relationship to patient: Spouse Parent Child Other:_____ Home Phone# (if different from above) (____)_____

Address (if different) _____ City_____ State_____ ZIP_____

Birthdate ___/___/___

Employer Name_____ Phone:_____

Business Address_____ City_____ State_____ ZIP_____

MEDICAL HISTORY

Physician's Name_____ Phone #: _____

Have you ever had any of the following? (Check boxes that apply):

❑ AIDS or Other Immunosupressive Disorders	❑Epilepsy	❑Psychiatric Care
❑ Allergies to Anesthetics	❑Fainting	❑Radiation Treatment
❑ Allergies to Medicine or Drugs	❑General Allergies	❑Recent Weight Loss
❑ Arthritis	❑Glaucoma	❑Respiratory Disease
❑ Artificial Heart Valves or Joints	❑Headaches	❑Rheumatic Fever
❑ Back Problems	❑Heart Murmur	❑Sinus Problems
❑ Blood Disease	❑Heart Problems	❑Special Diet
❑ Cancer	❑Hepatitis, Jaundice or Liver Disease	❑Stroke
❑ Chemical Dependency	❑Hemophilia	❑Swollen Neck Glands
❑ Chronic Diarrhea	❑High Blood Pressure	❑Tobacco Habit
❑ Chemotherapy	❑Low Blood Pressure	❑Thyroid problems
❑ Circulatory Problems	❑Nervous Problems	❑Ulcer
❑ Diabetes	❑Mitral Valve Prolapse	❑Venereal Disease
	❑Pacemaker	❑Other _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ❑ Yes ❑ No If so, what?_____

Have you ever responded adversely to medical or dental treatment? _____

For Women only: Do you suspect that you are pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No For what conditions? _____

List the medications you are currently taking _____

(PLEASE TURN OVER)

The information on the previous page is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentists or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____/____/____ Signature_____

DENTAL INSURANCE INFORMATION

Dental Insurance Company (primary) _____ Group #_____

Name of Insured: _____ Birthdate: ___/___/___ Social Security # _____-____-_____

Dental Insurance Company (secondary)_____ Group #_____

Name of Insured: _____ Birthdate: ___/___/___ Social Security # _____-____-_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____

Name of Insurance Company/ies

And assign directly to Dr. Rae Van Natta /Gentle Hands Dental Care LLC all 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 payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____ (initial) I have received a copy of the "NOTICE OF PRIVACY PRACTICES". **You may refuse to initial this acknowledgement.

Date ____/____/____ Signature_____

MINOR / CHILD CONSENT

I, being the parent or guardian of _____do hereby request

Name of minor/child

And authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date ____/____/____ Signature_____

FINANCIAL AGREEMENT

I acknowledge that payments is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date ____/____/____ Signature_____

____ (initial) I have received a copy of the DENTAL FINANCIAL POLICY.

APPOINTMENT CHANGE POLICY

Your appointment is a reservation.
You are required to give at least 48 hours' notice to make any changes to a prearranged appointment.
All prime-time appointments are VIP appointments. If a VIP appointment is changed or cancelled without 48 hours' notice, we will not offer another VIP appointment.
After two (2) changed or cancelled appointments without advanced notice, you will be required to put in a $25 deposit to reserve your next appointment.
After three (3) infractions, you will lose your privilege to make reservations in advance.
The administrator reserves the right to charge a $50 fee if failure to give us at least 48 hours' notice for any cancelled or changed appointments.
Also, our appointments run on a tight schedule, so please call us if you are going to be **15** minutes or more **late.**
We apologize for any inconvenience and sincerely hope that we can work together to satisfy all our patients.

Date ____/____/____ Signature_____