GALLANT DENTAL GROUP

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Patient Information

Name: _____ Birthdate: (DD/MM/YYYY)_____

Social Security Number:_____ Email Address: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Do you wish to receive electronic correspondence such as treatment reminders, updates, and appointment confirmations? ☐ Yes ☐ No

Employer: _____

Person to Contact in Case of Emergency: _____

Relationship to Patient:_____ Phone Number: _____

How did you hear about our office?

☐ Website ☐ Online Search ☐ Other _____

There is no greater compliment than when one of our patients refers a friend or family member to be a part of our office. If there is someone who gave you a referral, please list them below so we can send them a thank you!

Referred by: _____

Insurance Information

Name of Insured:_____ Relationship to Patient: _____

Insurance Company: _____ Group Number: _____

Do you have additional insurance? ☐ Yes ☐ No

Name of Insured:_____ Relationship to Patient: _____

Insurance Company: _____ Group Number: _____

Medical History

Physician Name: _____ Office Phone Number: _____

Are you under medical treatment now? ..... ☐ Yes ☐ No

Have you ever been hospitalized for any operation or serious illness? ..... ☐ Yes ☐ No

Are you taking any medications? ..... ☐ Yes ☐ No

If yes, what medications (s) are you taking?

_____

_____

_____

_____

_____

_____

Do you use tobacco?..... ☐ Yes ☐ No

Do you use alcohol, cocaine, or other drugs? ☐ Yes ☐ No

Are you allergic to any of the following?

Local Anesthetics..... ☐ Yes ☐ No

Penicillin..... ☐ Yes ☐ No

Sulfa Drugs..... ☐ Yes ☐ No

Barbiturates..... ☐ Yes ☐ No

Sedatives ..... ☐ Yes ☐ No

Iodine ..... ☐ Yes ☐ No

Aspirin ..... ☐ Yes ☐ No

Other ..... ☐ Yes ☐ No

Women Only:

Are you pregnant or think you might be pregnant? ..... ☐ Yes ☐ No

Are you nursing?..... ☐ Yes ☐ No

Are you taking birth control pills?..... ☐ Yes ☐ No

Do you have any of the following?

High Blood Pressure ..... ☐ Yes ☐ No
Heart Attack ..... ☐ Yes ☐ No
Rheumatic Fever ..... ☐ Yes ☐ No
Swollen Ankles ..... ☐ Yes ☐ No
Fainting/Seizures..... ☐ Yes ☐ No
Asthma ..... ☐ Yes ☐ No
Low Blood Pressure ..... ☐ Yes ☐ No
Epilepsy/Convulsions ... ☐ Yes ☐ No
Leukemia..... ☐ Yes ☐ No
Diabetes..... ☐ Yes ☐ No
Kidney Diseases..... ☐ Yes ☐ No
AIDS or HIV Infection..... ☐ Yes ☐ No
Thyroid Problem..... ☐ Yes ☐ No
Heart Disease ..... ☐ Yes ☐ No
Cardiac Pacemaker ..... ☐ Yes ☐ No
Heart Murmur ..... ☐ Yes ☐ No
Angina ..... ☐ Yes ☐ No
Frequently Tired..... ☐ Yes ☐ No
Anemia ..... ☐ Yes ☐ No
Emphysema ..... ☐ Yes ☐ No
Cancer ..... ☐ Yes ☐ No
Arthritis..... ☐ Yes ☐ No
Hepatitis/Jaundice..... ☐ Yes ☐ No
Stomach Troubles/Ulcers ☐ Yes ☐ No
Chest Pains ..... ☐ Yes ☐ No
Joint Replacement or Implant
..... ☐ Yes ☐ No
Easily Winded..... ☐ Yes ☐ No
Stoke..... ☐ Yes ☐ No
Hay Fever/Allergies ..... ☐ Yes ☐ No
Tuberculosis..... ☐ Yes ☐ No
Radiation Therapy..... ☐ Yes ☐ No
Glaucoma..... ☐ Yes ☐ No
Recent Weight Loss ..... ☐ Yes ☐ No
Liver Disease ..... ☐ Yes ☐ No
Heart Trouble..... ☐ Yes ☐ No
Respiratory Problems .... ☐ Yes ☐ No
Sexually Transmitted Disease
..... ☐ Yes ☐ No
Other ..... ☐ Yes ☐ No
_____

Dental History

Do your gums bleed while brushing or flossing?
..... ☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods?
..... ☐ Yes ☐ No
Are your teeth sensitive to sweet or sour liquids/foods?
..... ☐ Yes ☐ No
Do you feel pain to any of your teeth?..... ☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?...
..... ☐ Yes ☐ No
Have you had any head, neck or jaw injuries?
..... ☐ Yes ☐ No
Have you ever experienced any of the following problems in your jaw?
Clicking?..... ☐ Yes ☐ No
Pain (joint, ear, side of face?) ..... ☐ Yes ☐ No
Difficulty in opening or closing? ..... ☐ Yes ☐ No
Difficulty in chewing? ..... ☐ Yes ☐ No

Do you have frequent headaches?..... ☐ Yes ☐ No
Do you clench or grind your teeth?..... ☐ Yes ☐ No
Do you bite your lips or cheek frequently? ... ☐ Yes ☐ No
Have you ever had any difficult extractions in the past?
..... ☐ Yes ☐ No
Have your had any orthodontic work?..... ☐ Yes ☐ No
Have you ever has any prolonged bleeding following extractions?..... ☐ Yes ☐ No
Have you ever has instruction on the correct method of brushing your teeth? ..... ☐ Yes ☐ No
Have you ever had instruction on the care of your gums?.
..... ☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance 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.

Signature: X _____Printed Name: _____