Gentle Family Dentistry
Carl B. Holm, DDS, PC

**PATIENT NAME** (Last, First, MI)_____

**Address**_____**City**_____**State**_____**Zip**_____

**Home Phone**_____**Work**_____**Other (Cell)**_____

**Email address**_____**Employer**_____

**Sex**_____**DOB**_____**Age**_____**Marital Status** _____**SS#**_____

**Spouse Name**_____**Employer**_____**Phone** _____

Who is responsible for this account? (if other than yourself)_____
**SS#**_____**DOB**_____**Relationship**_____

**How do you prefer we contact you? Text**____ **Email**____ **Phone call**____ **All**____

*****Have you claimed bankruptcy** in last 6 months?_____Do you plan to in next 6 months?_____

Name of **Primary** Dental Ins _____Group #_____
Name of Suscriber_____ID#_____Birthdate_____
Name of **Secondary** Ins.(if applies)_____Group#_____
Name of Suscriber_____ID#_____Birthdate_____

**In case of Emergency**, who should be notified?_____**Phone #**_____
How did you hear of our dental office?_____

**Welcome to Gentle Family Dentistry!** We believe good health is your most precious asset. Good dental health is vital to a healthy body and essential for total well being. With proper care, you should be able to enjoy your teeth for a lifetime. Our goal is to help you achieve this in a gentle, professional manner.
**Appointments:** In order to serve you best, scheduled appointments must be kept. We reserve this time specifically for you and request you do all you can to keep appointments. If an emergency arises, please notify us as soon as possible, at least 24 hours notice, so that we may provide care for another patient.
**Financial Arrangements:** Payment is due at time of service. If you have dental insurance, we request your portion of the payment at the time of service. Please remember that the total treatment fee is the responsible party's obligation. Dental benefits are a contract between the patient and the insurance company. We are happy to assist you by filing the claims for you. If an account becomes delinquent, finance charges will be applied at the rate of 18%APR. Additional late fees may be applied.

**I HAVE READ AND UNDERSTAND THE PRECEDING ARRANGEMENTS**.

The information that I have provided 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 notify Dr. Holm or his staff of any changes. I authorize payment of dental insurance benefits to be made to Carl B. Holm, DDS, PC.

_____ _____
**PATIENT SIGNATURE (or guardian if under age 18)** **DATE**

Gentle Family Dentistry
Carl Holm DDS

**PATIENT NAME** (Last, First,MI) _____

**Physician's Name** _____**Date of last physical** _____

**Circle YES or NO, or write answers:**

Has there been any changes in your general health within the past year? …… Y / N

Have you had any serious illness or operations? ……..Y / N

Have you been hospitalized within the past two years? ……..……...Y / N

Have you ever taken the weight loss drug Fen Phen or Redux? ……Y / N

Do you smoke or use tobacco of any kind? ……..... .....…….....Y / N

Have you had abnormal bleeding with previous extractions or surgery? …….……Y / N

Have you ever had radiation therapy?……..... Y / N

Are you frequently thirsty?…..……Y / N Are you frequently hungry? ..…... Y / N

Do you urinate 6/more times a day?……...Y / N Family history of diabetes?…...…Y / N

**WOMEN:** Suspect you're pregnant?..Y / N Are you nursing?__Y / N Taking birth control?.. Y / N

********DO YOU HAVE OR HAVE YOU EVER HAD: (PLEASE CIRCLE ANSWERS)*******

| | | |
|---|---|---|
| High blood pressure | Epilepsy or Convulsions | Kidney Disease |
| Low blood pressure | Fainting spells or Sezures | Stomach/intestinal trouble |
| Heart attack | Hepatitis (A ,B or other) | Liver disease |
| Heart murmur | AIDS or HIV | Diabetes |
| Mitral valve prolapse | Syphilis, Gonorrhea, Herpes | Thyroid/parathyroid problem |
| Heart surgery/pacemaker | IV drug use | Arthritis |
| Chest pain upon exertion | Any respiratory disease | Joint Displacement |
| Swollen ankles | Asthma or Emphysema | Blood disorder or anemia |
| Rheumatic heart disease/fever | Sinus Problems | Transfusions |
| Stroke | Chronic cough/sore throat | Frequent headaches |
| Head or jaw injury | Coughing up blood | Chemical dependency |

********ARE YOU ALLERGIC TO OR HAD A REACTION TO: (PLEASE CIRCLE)********

| | | |
|---|---|---|
| Local anesthetics(Novocain, etc) | Aspirin | Barbiturates,sleeping pills |
| Penicillin, sulfa drugs, other antibiotics | Latex | Codeine, other narcotics |

**List any MEDICATIONS you are taking** (including over counter/self-prescribed)

_____

_____

**Is there anything else we should know about your medical history?**_____

_____

**Please tell us WHY you are seeking care at this time and if you have ANY concerns that we should be aware of?**_____

_____

**Dental History:**

Do you brush daily?……Y / N

Do you floss daily?……..……Y / N

Date of last Cleaning?_____

Date of last X-ray_____

Does dental work make you nervous?….. Y / N

Are you having any pain? ……...Y / N

**Please circle those that apply ( Do you have or have ever had)**

| | | |
|---|---|---|
| Frequent toothaches | Periodontal gum disease | Halitosis (bad breath) |
| Orthodontic treatment | Difficulty opening/closing Jaw | Grinding/clenching teeth |

**TO THE BEST OF MY KNOWLEDGE, ALL PRECEDING ANSWERS ARE CORRECT:**

**SIGNATURE OF PATIENT/Guardian_____DATE_____**