WELCOME

Chart#__________

Gill Dental Group
1-888-32-TEETH
www.GillDentalGroup.com

Stockton Livermore Modesto Turlock

PATIENT INFORMATION

Today's Date: ______________________________

Patient Name: ____

Patient's Date of Birth: ____________________

Patient's Address: ______________________________________

Patient's Social Security #: _________________

____

Patient's Phone #: ________________________

E-Mail ____

Cell Phone #: ____________________________

Patient's Age: _________________ Sex: ___________________

Marital Status: ___________________________

RESPONSIBLE PARTY

Responsible Party: ____

Date of Birth: ________________________________

Address: ____

Social Security #: ____________________________

____

Phone#: _____________________________________

____

Cell Phone #: ________________________________

Relationship to Patient: ____________________________________

Work Phone #: ______________________________

INSURANCE INFORMATION

Name of Insured: ____

Relationship to Patient: ______________________

Address: ____

Date of Birth: ________________________________

____

Social Security #: ____________________________

Employer: ____

Phone: ______________________________________

Address: ____

Union or Local #: _____________________________

____

Group #: ____________________________________

Insurance Company: _______________________________________

Phone #: ____________________________________

Address: ____

Member #:__________________________________

____

Family/Single Coverage: ____________________

ADDITIONAL INSURANCE

Name of Insured: ____

Relationship to Patient: ______________________

Employer: ____

Social Security #: ____________________________

Insurance Company: _______________________________________

Date of Birth: ________________________________

Address: ____

Phone: ______________________________________

____

Group #: ____________________________ _______

PATIENT DENTAL HISTORY

What is the reason for this visit: ____

When was your last dental visit? ________________________ What was done then? ___________________________________

How often did you visit the dentist before then: ____

Previous Dentist (Name and Location): ____

Have you had a complete series of Dental Films (X-Rays) taken: ___________When: __________ Where: _______________

Do you floss? How often ________________ How many times a day do you brush your teeth?________________________

Have you had surgery performed on your gums (Periodontal Treatment)? ____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WILL YOU CHANGE?

____

Have you experienced any of the following? (Please Circle)

Bleeding Gums	Sensitive Teeth	Painful Teeth
Clenching of Teeth	Grinding of Teeth	Frequent Headaches
Clicking of Jaw	Difficulty in opening/closing	Pain in Jaw/TMJ
Loose Teeth	Excessive Bleeding after Extraction	Food getting caught in Teeth

Do you wear?
Dentures: _______________ If Yes, Date of Placement: ____
Partials: ________________ If Yes, Date of Placement____

ACKNOWLEDGMENT OF RECIEPT OF PRIVACY PRACTICES AND DENTAL MATERIAL FACT SHEET
I acknowledge that I have received the following:
1/ Notice of Privacy Practices
2/ Dental Material Fact Sheet

_____ From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check here if you do not intend to be notified of such events.

APPOINTMENT CANCELLATION POLICY
We ask all patients for 24 hour notice to cancel an appointment. If we are not given 24 hours notice, there will be $35 charge to your account. This Policy is not meant to inconvenience our patients; this is just to keep appointment times available for all other patients including emergencies.

I authorize and request my insurance company to pay directly to the dentist or dental group, the insurance benefits otherwise payable to me. However, the 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 also understand that payment in full is expected at the time of service, unless prior arrangements have been made. Payment Plans are available on approval of Financing and any monthly payment that is delayed by 3 days will result in $25 Late Charge.

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 have been informed that all information is HIPPA compliant and will only be disclosed for medical or dental treatment.

____ Date: ______________________
Signature of Patient/Parent or Guardian

CONFIDENTIAL HEALTH HISTORY

Chart #_______

Gill Dental Group Inc.
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Stockton   Livermore   Modesto   Turlock

Patient Name: ____ Date of Birth: ___________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain____
4. Yes No Are you being treated by a physician now? If YES, explain______________________________
   Date of last medical exam? Reason for exam_______________________________________
5. Yes No Are you in pain now?
   If YES, explain____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: ____________________

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list: ____________________

VI. WOMEN ONLY (Please Circle)

Yes No Are you or could you be pregnant?
If YES, what month? ____________________

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS (Please Circle)

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ____________________

Yes No Have you ever been pre-medicated for dental treatment? If YES, why ____________________

Yes No Have you ever taken Fen-phen? If YES, when ____________________

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Physician's Name: ____________________ Phone Number: ____________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

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MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTISTINITIALS