

Gentle Family Dentistry
Adult Patient Registration and Medical History

(please fill out the front only)

Patient Information:

(last name)

(first name)

(middle initial)

(preferred name)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employed By: _____ Occupation: _____

Business Address: _____ City, State, Zip: _____

Business Phone: _____ Social Security No: _____

Email address: _____ May We Contact You Via Email? _____

Sex: M F Date Of Birth: _____ Marital Status: Single Married Widowed Divorced

Spouse's Information:

(last name)

(first name)

(middle initial)

Spouse Employed By: _____ Occupation: _____

Business Address: _____ City, State, Zip: _____

Business Phone: _____ Spouse's Social Security No: _____

In case of an emergency, who should we contact: _____

Relationship to patient: _____ Phone No: _____

Whom may we thank for referring you? _____

Medical History:

Physician's Name: _____ Date of last physical exam: _____

Have you ever had any of the following (check boxes that apply)

- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Circulatory Problems
- Nervous Problems
- Radiation Treatment
- Artificial Heart Valve/Pace Maker
- Artificial Joint
- Recent Weight Loss
- Back Problems
- Diabetes

- Headaches
- Hepatitis, Jaundice, Liver Disease
- Cancer
- Psychiatric Care
- Allergies To Medications/Drugs
- Allergies To Anesthetics
- General Allergies
- Blood Disease
- Respiratory Disease
- Epilepsy/Convulsion
- Asthma

- Arthritis
- Kidney/Liver Disease
- Abnormal Bleeding
- Special Diet
- Cosmetic/Plastic Surgery
- Heart Murmur
- Mitral Valve Prolapse
- Swollen Neck Glands
- Rheumatic Fever
- Sinus Problems
- Stroke

- Latex Allergy
- Ulcer
- Venereal Disease
- Chemical Dependency
- Hemophilia
- Tuberculosis
- Sleep Apnea/Snoring
- Mouth Breathing
- Bone Density Medication
- HIV, AIDS or Other
- Immunosuppressive Disorders

Any recent operations? (please list) _____

Any disabilities? (please list) _____

Drug allergies or adverse reactions (please list) _____

Currently under a physician's care (please explain) _____

Currently taking any medications or supplements (please list) _____

Women – Do you suspect you are pregnant? _____ Are you nursing? _____

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

The above information is accurate & complete to the best of my knowledge & is only for use in my treatment, billing, & processing of insurance. I will not hold my dentist or any member of the dental staff responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____ **Date:** _____

Gentle Family Dentistry

15430 W. National Ave.
New Berlin, WI 53151
262-797-8303

(please fill out both sides)

Credit Policy

Our sole purpose is to minimize your investment of keeping your teeth for the rest of your life. This luxury has now become commonplace through strong dental care and improved patient dental hygiene. To serve you from an administrative side of this process, we request the following information:

Billing Information:

Person responsible for this account: _____

Social Security #: _____ Driver's License #: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Credit Card Type: _____ Credit Card Number: _____

Expiration Date: _____

Primary Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Subscriber's Name (the person carrying the insurance): _____

Subscriber #: _____ Group #: _____

Subscriber's Date of Birth: _____

Secondary Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Subscriber's Name (the person carrying the insurance): _____

Subscriber #: _____ Group #: _____

Subscriber's Date of Birth: _____

Because of the wide range of payment plans, this document will also spell out our credit procedures allowing us to minimize the paperwork you have to do and enabling us to serve you at a lower cost.

1. A 10% discount will be offered, to our uninsured patients, if payment is made, in full, by cash or check at the time the services are rendered.
2. If our patients prefer to pay by credit card, we accept Master Card, Visa, Discover, & American Express.
3. We will submit claims for approved insurance plans on your behalf.
4. The patient is responsible for any co-payments and/or deductibles. These are due, if known, at the time of the visit.
5. **Any open balances remaining longer than 60 days after contacting the applicable insurance plans and/or the patient/guardian, may be applied to the listed credit card.**
6. Any returned checks will have a \$30.00 service fee added to the account.
7. Any outstanding amount that is 60 days past the date of service will be charged a 1% finance charge.
8. We offer 18 months interest free financing through Care Credit for approved patients.

Any appointment not cancelled with a 24 hour notice will be subject to a \$25-\$50 fee
_____ **Initial**

If you have any questions about your bill, or if you believe your bill contains an error, please call us immediately to discuss the situation. If the dispute cannot be resolved over the phone, then send a written inquiry to us within 60 days after the bill was mailed to your. Please provide in writing:

1. your full name
2. A descriptions of the error and why you believe the billing is in error
3. The dollar amount of the suspected error.

Thank you for your cooperation and allowing us to serve you.

I have read the above credit procedures and approve of their implementation.

Authorized signature: _____

Date signed: _____

Gentle Family Dentistry