

Matthew D. Gemp, D.M.D.

Patient Information (CONFIDENTIAL)

Date _____

Soc. Sec. _____

Birthdate _____

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Check Appropriate Box: Minor Single Married

If Student, Name of School / College _____ City _____ State _____ Full Time Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone: _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SSN# _____

Is this person currently a patient in our office? Yes No

IT IS THE POLICY OF THIS OFFICE TO MAKE DEFINITE FINANCIAL ARRANGEMENTS BEFORE ANY MAJOR WORK IS STARTED. IN ALL CASES REQUIRING LAB WORK SUCH AS CROWNS, DENTURES, OR BRIDGES WE REQUEST A MINIMUM DOWN PAYMENT OF 50%.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy / ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone# _____ How much is your deductible? _____ Max Annual Benefit _____

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 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.

X

Signature of patient (or parent if minor)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- 1. Are you under medical treatment now?..... Y / N
- 2. Have you been hospitalized for any surgical operation or serious illness within the last.....Y / N 5 yrs? If yes, please explain _____
- 3. Are you taking any medication(s) including non-prescription medications?Y / N If yes, what medication(s) are you taking _____
- 4. Do you use tobacco? Y / N

- 5. Are you allergic to or have you had any reactions to the following?
 - Local Anesthetics (e.g. Novocaine)..... Y / N
 - Penicillin or any other antibiotic..... Y / N
 - Sulfa Drugs..... Y / N
 - Barbiturates..... Y / N
 - Iodine..... Y / N
 - Aspirin..... Y / N
 - Any Metals(e.g. Nickel, mercury, etc.)..... Y / N
 - Latex Rubber..... Y / N
 - Other (please list)_____ Y / N

6. Women Only:
Are you pregnant or do you think you may be pregnant? Y / N

**For those patients using oral contraceptives: Please be advised that the use of certain antibiotics can reduce the effectiveness of Birth control. If you have concerns, please speak with Dr. Gemp.*

Do you have or have you had any of the following?

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

Patient Dental History

Reason for todays visit? _____ Last Dental visit (date)? _____

For What Reason? _____ Previous Dentist? _____

- 1. Do your gums bleed while brushing or flossing?..... Y / N
- 2. Are your teeth sensitive to hot or cold liquid/foods?..... Y / N
- 3. Are your teeth sensitive to sweet or sour liquids/foods?. Y / N
- 4. Do you feel pain in any of your teeth Y / N
- 5. Do you have any sores or lumps in or near your mouth?.Y / N
- 6. Have you had any head, neck or jaw injuries? Y/N
- 7. Have you ever experienced any of the following problems in your jaw?
 - Clicking Y / N
 - Pain (joint, ear, side or face)..... Y / N
 - Difficulty in opening or closing..... Y / N
 - Difficulty in chewing..... Y / N
- 8. Do you have frequent headaches?..... Y / N
- 9. Do you clench or grind your teeth? Y / N
- 10. Do you bite your lips or cheeks frequently? Y / N
- 11. Have you ever had prolonged bleeding following extractions? Y / N
- 12. Have you had any orthodontic treatment? Y / N
- 13. Do you wear dentures or partials? Y / N If yes, date of placement _____
- 14. Have you ever received oral hygiene instructions Regarding the care of your teeth and gums?..... Y / N
- 15. Do you like your smile? Y / N
- 16. If by magic, you could change anything about your teeth, what would you change? _____

Additional Comments _____