Gentling Dental Group
2443 West Kenosha Street
Broken Arrow, OK 74012

Patient Information:
Please completely answer the following information.

Name:____ Date: ______________
Last   First   Middle

☐ Male ☐ Female ☐ Single ☐ Married, Spouse: ________________ ☐ Child, Parents: ________________

Social Security Number: ______________ Birthdate: ____________ Employer: ________________

Address:_______________________________ City: ____________ State: ______ Zip: ________
Street   Apt #

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________ext_____

E-mail Address: ________________________

If full time student, school name: ________________________________ Grade:__________

Person Responsible for Account:
☐ Patient ☐ Mother/ Father ☐ Spouse ☐ Guardian

Name: ____________________________ ☐ Male ☐ Female ☐ Single ☐ Married, Spouse:____________

Social Security Number: ______________ Birthdate: ____________ Employer: ________________

Address: _______________________________ City: ____________ State: ______ Zip: ________
Street   Apt #

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________ext_____

E-mail Address: ________________________

Emergency Contact Not Living With You:
Name: ____ Relationship: ________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________ext_____

Insurance Information:
Please completely answer the following information.

Primary Insurance
☐ Patient ☐ Mother/ Father ☐ Spouse ☐ Other_________

Name: ____________________________________
Last   First   Middle

SS#: ______________ Birthdate: ____________

Employer: ______________________________

Insurance Co.: ______________ Group #: ________

Ins. Co. Phone: ______________ ID#: ________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ E-mail: ____________

Secondary Insurance
☐ Patient ☐ Mother/ Father ☐ Spouse ☐ Other___________

Name: ____________________________________
Last   First   Middle

SS#: ______________ Birthdate: ____________

Employer: ______________________________

Insurance Co.: ______________ Group #: ________

Ins. Co. Phone: ______________ ID#: ________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ E-mail: ____________

Insurance Disclaimer:
Dental insurance plans have exclusions, these help to keep premiums as low as possible for your employer. This makes your dental plan a supplemental coverage for your dental needs, and not designed to cover your treatment in its entirety. Dr. Gentling's goal is to identify, recommend and treat your dental needs in your best interest. ______________

Please initial

We do require that if patient is a child under the age of 18 a parent or guardian must accompany patient for all appointments for consent of treatment. ______________

Please initial

Payment and Treatment Authorization:
I hereby authorize and give consent for payments to be made directly to Gentling Dental Group. I understand that I am responsible for all dental treatment costs regardless of any insurance coverage. I hereby authorize Gentling Dental Group to administer medications and perform diagnostic, photographic and therapeutic procedures as may be necessary for my proper dental care. All information provided by me on my patient information, health history and dental history forms are correct to the best of my knowledge. I grant the right to Gentling Dental Group to release my dental/ medical and patient information to third party payers and/ or other health professionals. I understand Gentling Dental Group works with the District Attorneys office when fraudulent funds are issued. Services charges may apply to my account in addition to any NSF Check Fee. In the case of default of payment, I promise to pay any legal interest on the balance due, together with collection costs and just attorney fees incurred to collect on my account or future outstanding accounts.

Signature: ____ **Date:** ____________
Patient or Responsible Party

Drivers License Number: ____________________**State:** ________**Expiration Date**: __________

Method of Payment for Estimated Co-Payments at each appointment
☐ Cash ☐ Check, none over $500.00

☐ MC #__________________________ Expiration Date: ______________

☐ Visa #__________________________ Expiration Date: ______________

☐ Discover #__________________________ Expiration Date: ______________

☐ Care Credit #__________________________

Notes: Not all flexible spending account credit cards will allow dental charges to be processed.

Patient Name:______________________________ **Date:**______________
Last First Middle

Health History:

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

Artificial Joints	Y/ N	High Blood Pressure	Y/ N	Tuberculosis	Y/ N
Diabetes	Y/ N	Low Blood Pressure	Y/ N	Cancer	Y/ N
Artificial Heart Valves	Y/ N	AIDS/ HIV Positive	Y/ N	Cancer treatment	Y/ N
Hepatitis A, B or C	Y/ N	Recent Surgery	Y/ N	Asthma	Y/ N
Heart Surgery	Y/ N	Epilepsy/Seizures	Y/ N		
Heart Trouble/ Disease	Y/ N	Liver Trouble/ Disease	Y/ N	***WOMEN*:**	
Stroke	Y/ N	Lung Trouble/ Disease	Y/ N	Are you Pregnant?	Y/ N **Due Date:** _______
Pacemaker	Y/ N	Kidney Trouble/ Disease	Y/ N	Take Bisphosphonate?	Y/ N

If you answered Yes, please explain: ______________________________

Do you have *family history* of heart conditions? **Y/ N**
Are you currently under the care of a physician? **Y/ N**
Explain:______________________________
Are you currently taking any medications (include prescription, over-the-counter, herbal)? **Y/ N**
Please list: ______________________________
Do you have any other disease, condition or problem not listed that the doctor should know about? **Y/ N**
Explain: ______________________________
Do you smoke or use tobacco products? **Y/ N**
Have you been hospitalized in the last two years? **Y/ N**
Explain: ______________________________

Are you allergic to or have you ever had an allergic reaction to:

Latex	Y/ N	Tetracycline	Y/ N
Penicillin/Amoxicillin	Y/ N	Iodine or Shell Fish	Y/ N
Clindamycin	Y/ N	Lortab (Hydrocodone)	Y/ N
Dental Anesthesia (Novocain-like drugs)	Y/ N	Aspirin	Y/ N
Codeine	Y/ N	Ibuprofen	Y/ N

Allergies to any other medications: Please list: ______________________ **Y/N**

Physician Name: ______________________ **Clinic:**____________ **Phone:** ______________

Dental History: Please answer the following questions.

How did you hear about us? ______________________________
Reason for today's visit? ______________________________
How long has it been since your last dental visit? ____________ Reason: ______________________
Are there any areas of concern you have regarding your mouth? ______________________________
Do you have any *family history* of periodontal disease/conditions? **Y/ N**
Have you ever or do you clench or grind your teeth? **Y/ N**
Have you ever experienced popping or discomfort in the jaw joint? **Y/ N**
Do your gums bleed when you brush or floss? **Y/ N**
Have you ever been told you have gum disease or periodontal disease? **Y/ N**
Have you ever had a deep cleaning/ scaling and root plaining? **Y/ N**
If so, when? ______________________

How nervous are you about dental treatment?
Not at all 1 2 3 4 5 6 7 8 9 10 Extremely Nervous

I certify to the above statements regarding my medical and dental conditions that the information provided is complete and accurate.

Signature: ______________________________ **Date:** ____________
Patient or Responsible Party

Thank you for choosing Gentling Dental Group. We want your visit to be pleasant and comfortable.

Office Use Only

☐ Posted ________
Reviewed By: ______________________________ Date: ______________________
Information Received
☐ Insurance Card ________
☐ Drivers License ________

Patient Name:____ **Date:**________________________
Last First Middle

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the notice.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____ **Date:** ________________________
Patient or Responsible Party

Consent for Release of Medical Information

I hereby grant Gentling Dental Group permission to contact me and leave messages pertaining to my dental care (including calling to remind me of appointments, to inform me of referral appointments, test results, prescription information, etc.) by a recording device or with the following persons (please consider listing spouse, parents, step-parents, grandparents, children, secretary, etc)

Name: ____________________________________ **Name**: ______________________________

Name: ____________________________________ **Name**: ______________________________

This consent will remain in effect throughout our dentist-patient relationship unless withdrawn in writing by patient. I am aware that signing this form may cause disclosure of confidential or privileged information to those designated by me. I have been given the opportunity to read the consent and receive clarification of any questions I may have, and to obtain a copy.

Signature: ____ **Date:** ________________________

Consent of Reviewed Office Polices

I have had an opportunity to review a copy of Gentling Dental Group office polices. I understand that I may request a copy. Information included the following:

1. How we work with insurance companies
2. Payment Options
3. **48 hour Cancellation Policy**
   * Confirmation by returning our phone call is required to keep your reserved appointment date and time
4. **Confirmation of Appointments**
   * We give a courtesy call 24 to 48 hours in advance of your appointment.
   * We will call your phone numbers and leave a message for you to call us back to confirm your reserved appointment.
   * Confirmation by returning our phone call is required to keep your reserved appointment date and time.

Signature: ____ **Date:** ________________________