# Annette Merlino DMD
# Gentle Family Dentistry

Name_____Age_____Birth date_____Sex_____

Address_____City_____State_____Zip_____

Home #_____Cell #/Carrier_____Work Phone_____

E-mail_____Emergency Contact_____Phone_____

Employer_____Social Security #_____Occupation_____

Marital Status_____How were you referred to us?_____

Spouse/Parent's name_____Contact Phone_____

## Insurance Information

### Primary Insurance

Subscriber Name_____Relationship to patient_____

Subscriber Birth date_____Social Security #_____

Subscriber employer_____Insurance Company_____

Group #_____Policy/ID#_____Deductible_____

Maximum yearly benefit_____Does pat. have a secondary ins.?_____

### Secondary Insurance

Subscriber Name_____Relationship to patient_____

Subscriber Birth date_____Social Security #_____

Insured employer_____Insurance Company_____

Group #_____Policy/ID#_____Deductible_____

Maximum yearly benefit _____

### Authorization and Release

I certify that I understand all of the questions and have answered them accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and treatments 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 dentist or dental group 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 on my behalf or my dependents. **I further recognize that I may be charged interest for balances that are more than three months outstanding and any further fees incurred during the collection process.**

X_____Date_____

Signature of patient (or parent/guardian if minor)

## Health History

Are you allergic or have you ever had a reaction to any of the following?

| | | | | |
|---|---|---|---|---|
| ___ Aspirin | ___ Codeine | ___ Iodine | ___ Local Anesthetic | ___ Sulfa Drugs |
| ___ Barbiturates | ___ Erythromycin | ___ Latex Rubber | ___ Penicillin | ___ Tetracycline |

Other: _____

Are you currently under a physicians care? _____ If yes, for what? _____

Physicians name _____ Last Visit _____ Phone #_____

Please list all medications you are taking and the correlating diagnosis:_____
_____
_____

Have you ever had or currently do have any of the following? **Check only those that apply.**

| | | |
|---|---|---|
| ___ Abnormal Bleeding | ___ Blood Transfusion | ___ Low Blood Pressure |
| ___ Allergies | ___ Diabetes | ___ Mitral Valve Prolapse |
| ___ Anemia | ___ Difficulty Breathing | ___ Rheumatic Fever |
| ___ Angina Pectoris | ___ Epilepsy | ___ Sinus Trouble |
| ___ Arthritis | ___ Headaches | ___ Stroke |
| ___ Artificial Joints | ___ Glaucoma | ___ Swelling Limbs |
| ___ Artificial Valve | ___ Hemophilia | ___ Thyroid Problems |
| ___ Asthma | ___ High Blood Pressure | ___ Tuberculosis |
| ___ Back Issues | ___ Kidney Disease | ___ Ulcers |

___ Heart Attack; If yes when? _____ Were you given a Pace maker/Defibrillator? _____
___ Hepatitis; If yes which type? _____
___ Sexually Transmitted Disease; If yes please specify _____
___ Cancer; If yes did you have radiation? _____ Did you have Chemotherapy? _____
___ Tobacco use; If yes what type and how often? _____

Please list any other medical information that you feel is important for us to know. _____
_____
_____

### Women only

___ Are you pregnant or think you are pregnant? If yes what is your Due Date? _____
___ Are you nursing?
___ Are you using birth control? If yes please specify _____
(Please note some birth control medications can effect blood pressure and cause health risks.)

## Dental History

Previous Dentist _____ Last Dental Visit _____

Please list any dental issues you are having or any previous issues such as, bleeding gums, pain, sores or abnormal growths in mouth._____
_____
_____

### Acknowledgment of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact the practice for further information.

X_____Date_____
Signature of patient (or parent/guardian if minor)