

Gubler Dental

Treating you like family. A tradition since 1970.

Patient Information

Date _____ ID#/SS# _____

Patient _____

Address _____

Home () _____ Work () _____ Ext. _____ Spouse's Work () _____

Best time to reach you _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone () _____

Spouse's Name _____

Spouse's Birthdate _____ SS# _____

Spouse's Occupation _____

Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone () _____ Work Phone () _____

How did you hear about us? Brochure/Flyer Yellow Pages Newspaper Sign Other
(Check all that apply) Family Friend Name: _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Dental History

Reason for today's visit _____

Former Dentist _____ City/State _____

Date last dental visit _____ Date of last dental X-rays _____ Last dental cleaning _____

Check (✓) if you have had any of the following:

- Bad breath
- Cigarette, pipe, or cigar smoking
- Clicking or popping jaw

- Food collection between the teeth
- Grinding teeth
- Gums swollen or bleeding
- Jaw pain or tiredness
- Loose teeth or broken fillings
- Mouth breathing / snoring
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to cold / heat
- Sensitivity to sweets

- Sensitivity when biting
- Sores or growths in your mouth
- How often do you floss? _____
- How often do you brush? _____

Health History

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tumor or growth on head or neck |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Weight Loss, unexplained |
| <input type="checkbox"/> Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | Blood Pressure _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care | Date: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis Type | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | |

Have you ever taken any of the drugs collectively referred to as "fen-phen?" Yes No

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing Yes No

Taking birth control pills? Yes No

Medications

List any medications you are currently taking and why you are taking them. _____

Allergies

- | | | | |
|--|----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Iodine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Other _____ | | | |

Authorization & 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 my treatment or examination rendered to my child or me during the period of such dental care to third party payer/and or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. In the event that full payment of all services rendered on behalf of my dependents. In the event that full payment for charges incurred in my dental care is not made, I agree to pay all costs of collection, including late & collection fees, reasonable attorney's fees, and interest at the rate of eighteen percent (18%) per annum. I also agree to submit myself to the jurisdiction of the courts of Clark county. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.

Signature of Patient (or Parent if Minor) _____ date _____

Doctor's signature _____ date _____