

Dr. Jack L. Gish & Associates, P.C.
General and Cosmetic Dentistry

Name _____ Date _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Phone () _____

Physician _____ City/Town _____ Cell Phone () _____

Social Security # _____ - _____ - _____ Work Phone () _____

Occupation _____ Employer _____

Whom can we thank for referring you to our office? _____

Medical History

1. Are you under any medical treatment now? (Explain) _____ YES NO
2. Have you had any major operations? If so, what? _____ YES NO
3. Do you have any prosthetic devices such as artificial joints, heart valves, pins, or plates? Explain _____ YES NO
4. Have you had any adverse affects to any drugs including penicillin? YES NO
5. Have you had any adverse response to local anesthetic, Novocain, nitrous gas? YES NO
6. Are you allergic to any materials that cause hives, asthma, eczema, etc? YES NO
7. Generally, are you in good health at this time? YES NO
8. Do you have any wounds that heal slowly? YES NO
9. Have you ever had prolonged bleeding, including after tooth extraction? YES NO
10. Do you have a history of fainting? YES NO
11. Do you have a history of cancer? YES NO
12. Are you pregnant? If so, what trimester? _____ YES NO
13. Do you smoke? YES NO

Please circle if you have or had any of the following problems or diseases

- | | |
|---------------------------|--------------------------------------|
| High Blood Pressure | Tuberculosis |
| Blood Disease | HIV Positive or AIDS |
| Prosthetic Cardiac Valves | Diabetes |
| Bacterial Endocarditis | Hepatitis, Jaundice or Liver Disease |
| Venereal Disease | Rheumatic Fever |

- 14. Do you have pain near your ears? YES NO
- 15. Do you have any unhealed injuries in or around your mouth? YES NO
- 16. Do you have any inflamed areas in or around your mouth? YES NO
- 17. Do your gums bleed? YES NO
- 18. Have you had instruction on how to brush/floss properly? YES NO
- 19. Do you habitually clench your teeth during the night or day? YES NO
- 20. When was your last dental visit? _____ YES NO
- 21. Is any part of your mouth sore to pressure or irritants (cold, hot, sweet, etc)? YES NO
- 22. Do you presently have any dental complaints? YES NO
- Please specify areas of concern _____
- 23. Are there areas of cosmetic dentistry that you would like the dentist to address? YES NO
- 24. Are you currently taking any medications or drugs? List: _____ YES NO

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Signature

Important Billing Notice

Payment in full for your dental services is required at the time of your visit unless you make other arrangements with us in advance. We will assist you in securing payment for these charges from your insurance company, but you should be aware that many dental policies pay a fixed allowance for certain procedures while others will only pay a percentage of the charge. You are responsible for the payment of any deductible amount, co-insurance, or other balance not paid by your insurance company for any reason.

If any bill is not paid within 90 days of the date it is mailed to you, your account will be turned over to a collection agency and assessed a 15% surcharge. You are responsible for all attorney fees, court costs and other costs of collection we incur in attempting to collect the balance you owe.

There is a \$45 charge for all missed appointments and/or cancellations without 24 hours notice.

By signing below you acknowledge that you understand and agree to these terms.

Signature

If we can be of any further assistance, or if you have any questions, please do not hesitate to ask.