**Patient Name_____** **We'd like to get to know you better!**

Gentle Touch Family Dentistry
271 S Main Street
Tooele, UT 84074

P: 435-882-3700
F: 435-882-4588
E: ericpalmerdds@gmail.com
tooelegentletouchdentistry.com

## Personal Information

Prefer to be called:_____ Gender: _____ Date of Birth:_____Today's Date:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Place of Employment: _____

Driver's License:_____ SSN:_____

Marital Status? Circle one: Married Single Divorced Minor Email:_____

Emergency Contact:_____ Phone:_____Relationship_____

Person financially responsible for this account?_____Relationship:_____

## Primary Insurance

Name of the insured:_____DOB:_____Relationship_____

Dental Insurance Co:_____Group #_____ID#_____

Employer:_____Occupation:_____

## Secondary Insurance

Name of the insured:_____DOB:_____Relationship_____

Dental Insurance Co:_____Group #_____ID#_____

Employer:_____Occupation:_____

## Assignment and Release, Financial Policy

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Gentle Touch Family Dentistry insurance benefits, if any, payable to be for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the release of information necessary to secure payment of benefits.

## Appointment Policy

I agree to provide 48 hours notice if cancellation of my appointment is needed. I agree to a $50 broken appointment fee if this notice is not provided. I understand that dismissal from the office may occur after two broken appointments.

**Signature:_____ Date: _____**

**Patient Name_____** **Medical History & Privacy Agreement**

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**Please circle Yes or No for any of the following that apply to you:**

| | | | |
|---|---|---|---|
| Y N Heart Attack or Heart Trouble | Y N Pacemaker | Y N Tobacco Use | Y N Osteoporosis |
| Y N Congenital Heart Disease | Y N Excessive Bleeding | Y N Asthma | Y N Epilepsy |
| Y N Artificial Heart Valve | Y N Diabetes | Y N Kidney Problems | Y N Tumors/Cancer |
| Y N High Blood Pressure | Y N Stroke | Y N Drug/Alcohol Dependency | Y N Tuberculosis |

**Please list any medications you regularly take and why:**

_____

_____

_____

**Please list any allergies you have, including to latex and penicillin:**

_____

_____

**Are you pregnant?** Y N **If so, when are you due?**_____

**Any hospitalization in the last two years?**_____

**Dental History**

Reason for today's visit?_____ Last dental visit? _____

***Here at Gentle Touch Family Dentistry, we offer a variety of services to enhance your comfort and keep your smile beautiful. Please circle any services below you would like a staff member to speak with you about.***

| | | |
|---|---|---|
| Teeth Whitening | Cosmetic Crowns | Clear Braces / Invisalign |
| Relaxing Gas | Implants | Veneers |
| Bite Guard / Clenching Prevention | Protective Sealants | Extended Payment Plans |

**Signature of patient or responsible party:_____** **Date: _____**

**Privacy Notice and Agreement**

Gentle Touch Family Dentistry will protect your personal information using practices compliant with the Health Insurance Portability and Accountability Act (HIPAA). We will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed notice of privacy of practices available in paper form available upon request to help you better understand our policies in regard to protected health information. I acknowledge, understand and agree to the proper use of personal information described in the notice and privacy practices.

**Signature of patient or responsible party:_____** **Date:_____**