GILREATH DENTAL ASSOCIATES
PATIENT REGISTRATION

Patient Information

First Name:_____Last Name:_____Middle Initial:_____

Preferred Name:_____

Address: _____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____Social Security #:_____

If you would like us to confirm appts via email, please give us your email address:_____

If you are a student, are you full time or part time? _____

Please circle: Female or Male Marital Status: Married Single Divorced Separated Widowed

Are you here to see Dr. Gilreath Sr or Dr Gilreath Jr. Preferred Pharmacy and phone:_____

Referred By:_____

If you have insurance, are you the Policy Holder? (please circle) Yes No

Responsible Party Information (if someone other than the patient)

First Name:_____Last Name:_____Middle Initial:_____

Address: _____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____Social Security #:_____

Primary Insurance Information

Name of subscriber to policy_____

Your relationship to subscriber: ○ Self ○ Spouse ○ Child ○ Other

Employer ID: _____Carrier ID:_____

Subscriber Birth date:_____ Subscriber Social Security #:_____

Employer:_____ Insurance Company:_____

Address:_____

Address 2:_____

City, State, Zip:_____

Secondary Insurance Information

Name of subscriber to policy_____

Your relationship to subscriber: ○ Self ○ Spouse ○ Child ○ Other

Employer ID: _____Carrier ID:_____

Subscriber Birth date:_____ Subscriber Social Security #:_____

Employer:_____ Insurance Company:_____

Address:_____

Address 2:_____

City, State, Zip:_____

GILREATH DENTAL ASSOCIATES
MEDICAL and ORAL HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, health problems that you may have or medications that you may be taking can have an important interrelationship with the dentistry you will recieve. Thank you for answering the following questions.

*Patient Name*_____ *Birthdate* _____

Teeth and Gums Health

How often do you brush? _____ How often do you floss? _____
Do you gums bleed when you floss? ..... ☐ Yes ☐ No
Have you had any periodontal (gums) problems or treatment?..... ☐ Yes ☐ No
Have you lost any teeth? ..... ☐ Yes ☐ No
If so, have you had these teeth replaced? ..... ☐ Yes ☐ No
If not, why?_____
Are any teeth sensitive to cold, hot or pressure?..... ☐ Yes ☐ No
Do any of your teeth hurt now or in the recent past? ..... ☐ Yes ☐ No

General Health

Are you under a physicians care now for any active problem? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized for serious condition or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills or drugs (prescription or non-prescription)? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Do you use tobacco (smoking or chewing)? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Are you allergic to any drug or to latex? ☐ Yes ☐ No If yes, please explain: _____

Women:
Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you have or have you had any of the following medical conditions?:

AIDS/HIV Positive	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Drug/Alcohol Addiction	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Unplanned Weight Loss	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Herpes (oral)	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No
Cancer (skin)	☐ Yes	☐ No	GI Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer (other)	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors or growths	☐ Yes	☐ No
Cortisone (steriods)	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No

Please let us know about any other medical or dental problems:

To the best of my knowledge, the questions on this form have been accurately answered. I understand thaty providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN_____ DATE _____

Smile Analysis

In an effort to understand your wants and needs, please take a few minutes to fill out this Smile Analysis. Even if you are not interested in enhancing your smile at this time, it is very helpful for us to understand how you feel about your teeth and smile so that we can probably serve your needs now and in the future. In addition to xrays, we also use digital photography to evalute your dental needs. By signing this form, you authorize us to take photographs of you and your teeth.

1. Do you like the way your smile looks? ☐ Yes ☐ No
2. Do you feel self conscious about showing your teeth when you laugh or smile? ☐ Yes ☐ No
3. Do you have any prior dental work that appears unnatural? ☐ Yes ☐ No
4. Are any of your teeth yellow, stained or somewhat discolored? ☐ Yes ☐ No
5. Are your gums red, sore, puffy, bleeding or receded? ☐ Yes ☐ No
6. Would you like your teeth to be whiter? ☐ Yes ☐ No
7. Have you ever bleached your teeth? ☐ Yes ☐ No
8. Do you have any gaps or spaces between your teeth? ☐ Yes ☐ No
   - If Yes, do they bother you? ☐ Yes ☐ No
   - Do you get food caught in the gaps when you eat? ☐ Yes ☐ No
9. Are any of your teeth turned, crooked, or uneven? ☐ Yes ☐ No
10. Are you missing any teeth? ☐ Yes ☐ No
11. Do you see any pitting or defects on the surfaces of your teeth? ☐ Yes ☐ No
12. Are the edges of your front teeth worn down, chipped or uneven? ☐ Yes ☐ No
13. Do you have a "gummy" smile (too much of your gums show when smiling)? ☐ Yes ☐ No
14. Do you like the shapes of your teeth? ☐ Yes ☐ No

    If not, why?_____

15. If you could change anything about your smile, it would be (check all that apply):

- ☐ Color of your teeth
- ☐ Crooked or mis-aligned teeth
- ☐ Gaps between your teeth
- ☐ Size/Shape of your teeth
- ☐ Crowns are not real looking
- ☐ Too much or too little of gum shows when you smile
- ☐ Too much or too little of teeth show when you smile
- ☐ Silver fillings show
- ☐ Fillings in front teeth are discolored
- ☐ Crowns or bridges that show metal at gum line

16. Do you have (check all that apply):

- ☐ Sensitive or receding gums
- ☐ Worn/broken/chipped teeth
- ☐ Old crowns that have dark edges at the top
- ☐ Old or discolored fillings
- ☐ Missing teeth

17. If you work outside the home, do you (check all that apply):

- ☐ Visit businesses or clients
- ☐ Travel
- ☐ Speak publicly
- ☐ Deal with the public on a one on one basis

18. If you had a your smile enhanced, do you think you'd feel (check all that apply):

- ☐ More confident
- ☐ More optimistic
- ☐ Healthier
- ☐ Just OK
- ☐ No different
- ☐ Not sure

19. Do you or someone in your family have issues with any of the following (check all that apply):

- ☐ Chronic bad breath
- ☐ Grinding teeth
- ☐ Snoring

20. Please write down any other concerns you have about your teeth, oral health or your smile.

_____ _____

Signature Date

GILREATH DENTAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Please Note: It is your right to refuse to sign this acknowledgement.

IF YOU ARE THE PATIENT,
I acknowledge that I have received a copy of Gilreath Dental Associates' HIPAA Notice of Privacy Practices.

_____
Patient Name (Please print)

_____ _____
Patient Signature Date

IF YOU ARE A PARENT, GUARDIAN, POWER OF ATTORNEY,
I acknowledge that I have received a copy of Gilreath Dental Associates' HIPAA Notice of Privacy Practices.

_____
Patient Name (Please print)

_____ _____
Signature of Personal Representative Date

Acting as ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other

Dental Office Use Only

I tried to obtain written Acknowledgement of receipt of our Notice of Privacy Practices by the individual noted above, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other:

_____ _____
Staff Member Signature Date