WELCOME to
Giesting Family Dentistry

Today's Date: _____/_____/_____

Name: ___________________________,___________________,_____ What you prefer to be called: _______________
Last First MI
Address: _______________________________________,______________,____, _______ Male ___ Female___
City St Zip
Home Phone #: ___________________________ Work Phone #:_______________________________ EXT:________
Cell Phone #: ____________________________ DOB: ____ /____ /_____ Age: _____ SS#: _______________________
Employer: _____________________________________ How Long?: ____________ Occupation : __________________
Employer Address: _______________________________________,_________________________,_____ , ______________
City St Zip
Status: Minor ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___
Spouse's Name: ___________________________________ Do you have children? Yes ___ No___ How Many? _____

In case of emergency please notify: Name _____________________________ Relation: _________________
Home phone #: _______________________ Work Phone # ______________________Cell #: ______________________
Physician Name: ____ Phone #: _____________________________

Insurance Information

Primary Dental Insurance Co. Name: ____
Address: _______________________________, ____________________, ____, ______ Phone#: _____________________
City St Zip
Insured's Name __________________________ Address _______________________________ DOB ___ /___ /______
Insured's SS#: _________________ Grp# _________Insured's ID # _________________ Relation: __________________
Insured's Employer: ____________________________ Address: _______________________ , ______________, ___, _____
Phone#: _______________________________ City St Zip
Secondary Dental Insurance Co. Name: ______________________________________
Address: _______________________________, ____________________, ____, ______ Phone#: _____________________
City ST Zip
Insured's Name __________________________ Address _______________________________ DOB ___ /___ /______
Insured's SS#: _________________ Grp# _________Insured's ID # _________________ Relation: __________________
Insured's Employer: ____________________________ Address: _______________________ , ______________, ___, _____
Phone#: _______________________________ City St Zip

Account Information

Person ultimately responsible for account: Name: ____
Relation: ___________________________ Address: ______________________________, _______________, ____, ______
City St Zip
DOB: ____/____/______ SS#: ____________________________ Drivers License # : ______________________________
Work Phone #: _____________________ Payment Method: Cash ____ Check ____ Credit Card____
Enter Credit Card #: _____________________________ Exp date _____ /_____

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I
(Initial) fully understand I am solely responsible for any balance not paid by my insurance company.

PLEASE CONTINUE ON BACK

Dental History

Reason for your visit today: Exam___ Emergency___ Consultation___ Are you in Pain? Yes___ No___ How Long?__________

Please check any of the following problems: Discomfort, clicking or popping in jaw ____ Teeth grinding_____

Red, swollen or bleeding gums____ Locking jaw___ Sensitive tooth, teeth or gums___ Bad breath___

Blisters/Sores in or around mouth___ Broken/Chipped tooth___ Ringing in Ears ___ Stained teeth___

Lost/Broken filling(s) ___ Other: ____

Do you require pre-medication? Yes ___ No ___ Don't Know ___

Previous Dentist: ____ (______) ______________________

Last Dental Exam ___/___/______ Last Dental X-rays ___/___/______ Times a day you brush? ___________

Times a day you floss? _____ What type of tooth bristles do you use? Soft ___ Medium ___ Hard ___

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History

Are you taking any of the following medications? Nerve pills___ Pain killers (including aspirin)___

Stimulants___ Blood Thinners ___ Tranquilizers ___ Insulin ___

Other(s) please list: ____

Are you allergic to any of the following? Aspirin ___ Penicillin/Amoxicillin ___ Tetracycline ___

Codeine___ Dental Anesthetics ___ Sulfa ____ Latex ____ Others: ____

Rate your general health from 1 -10 ______

Have you ever had a serious head or neck injury? Yes ___ No ___

Have you ever taken the drug Phen-fen and or Redux Yes ___ No___

Are you or have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates Yes ___ No ___

Are you on a special diet? Yes ___ No ___ Do you wear contacts? Yes ___ No___

Do you use tobacco? No___ Yes ___ How used? ________ How much? _________ How long? _______

Are you currently taking a controlled substance? Yes ___ No___

For Women: Are you taking Birth Control pills Yes___ No___ How many children have you had? _______

Are you pregnant? No___ Yes____/How long? _________ Are you nursing? Yes ___ No___

Do you have or have you had any of the following diseases, medical conditions or procedures?

AIDS/HIV Positive	Yes	Cortisone Medication	Yes	Hemophilia	Yes	Radiation Treatment	Yes
Alzheimer's Disease	Yes	Diabetes	Yes	Hepatitis A	Yes	Recent Weight Loss	Yes
Anaphylaxis	Yes	Drug addiction	Yes	Hepatitis B or C	Yes	Renal Dialysis	Yes
Anemia	Yes	Easily Winded	Yes	Herpes	Yes	Rheumatic Fever	Yes
Angina	Yes	Emphysema	Yes	High Blood Pressure	Yes	Rheumatism	Yes
Arthritis/Gout	Yes	Epilepsy or Seizures	Yes	High Cholesterol	Yes	Scarlet Fever	Yes
Artificial Heart Valve	Yes	Excessive Bleeding	Yes	Hives or Rash	Yes	Shingles	Yes
Artificial Joint	Yes	Excessive Thirst	Yes	Hypoglycemia	Yes	Sickle Cell Disease	Yes
Asthma	Yes	Fainting Spells/Dizziness	Yes	Irregular Heartbeat	Yes	Sinus Trouble	Yes
Blood Disease	Yes	Frequent Cough	Yes	Kidney Problems	Yes	Spina Bifida	Yes
Blood Transfusion	Yes	Frequent Diarrhea	Yes	Leukemia	Yes	Stomach/Intestinal Disease	Yes
Breathing Problems	Yes	Frequent Headaches	Yes	Liver Disease	Yes	Stroke	Yes
Bruise Easily	Yes	Genital Herpes	Yes	Low Blood Pressure	Yes	Swelling of Limbs	Yes
Cancer	Yes	Glaucoma	Yes	Lung Disease	Yes	Thyroid Disease	Yes
Chemotherapy	Yes	Hay Fever	Yes	Mitral Valve Disease	Yes	Tonsillitis	Yes
Chest Pains	Yes	Heart Attack/Failure	Yes	Osteoporosis	Yes	Tuberculosis	Yes
Cold Sores/Fever Blisters	Yes	Heart Murmur	Yes	Pain in Jaw Joints	Yes	Tumors or Growths	Yes
Congenital Heart Disorder	Yes	Heart Pacemaker	Yes	Parathyroid Disease	Yes	Ulcers	Yes
Convulsions	Yes	Heart Trouble/Disease	Yes	Psychiatric Care	Yes	Venereal Disease	Yes
						Yellow Jaundice	Yes

Please list any other surgeries or medical conditions you have or ever had: ____
____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit. If an account is not paid within 90 days of the date of service you will be responsible for legal fees, collection fees, interest charges and any other expenses incurred in collecting your account. Currently, these rates are at 40% of balance.

I authorize the staff to perform any necessary services needed during the diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____ Date ____/_____/_________