Gentle Dental Care

Donald H. Lough Jr. DDS

98 Washington Avenue
Wheeling, WV 26003
304-243-9010

Name _____ Date of Birth _____
First Last MI

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security _____ Employer _____ Marital Status M S D W

Nearest friend/relative not living with you _____ Phone _____ How did you hear of our office? _____

Person responsible for account _____ Phone _____
First Last MI

If Full Time Student: Name and Address of School _____

If Under Age of 21: Names of both parents _____

Who Has Legal Custody? _____ Who Has Financial Responsibility**?** _____

Primary Insured _____ Date of Birth _____
First Last MI

Street Address _____ City _____ State _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security _____ Employer _____

Dental Insurance Co. _____ ID# _____ Group# _____

Dental Insurance Address _____ Phone _____

Secondary Insured _____ Date of Birth _____
First Last MI

Street Address _____ City _____ State _____

Home phone _____ Cell Phone _____ Work Phone _____

Social Security _____ Employer _____

Dental Insurance Co. _____ ID# _____ Group# _____

Dental Insurance Address _____ Phone

The information on this page and the dental/medical histories are correct to the best of my knowledge.
I hereby authorize payment of the insurance benefits directly to the Dental Office. I understand that I am responsible for all costs of Dental treatment and payment is due at the time service is provided. I understand that my insurance policy is a contract between myself and my insurance provider and that I am ultimately financially responsible for covered services. If the insurance payment is less than originally estimated, the remaining balance becomes my responsibility.

Signature_____ **DATE**_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized 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?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonate?	Yes	No	
Do you have or have you ever had acid reflux or GERD?	Yes	No	

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	Shingles	Yes	No	Recent Weight Loss	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No	Breathing Problem	Yes	No
Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No	Bruise Easily	Yes	No
High Blood Pressure	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No	Cancer	Yes	No
Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No	Chemotherapy	Yes	No
Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No	Chest Pains	Yes	No
Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Murmur	Yes	No	Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No
Yellow Jaundice	Yes	No	Convulsions	Yes	No	Heart Trouble/Disease	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

Physician's name_____

Comments: _____

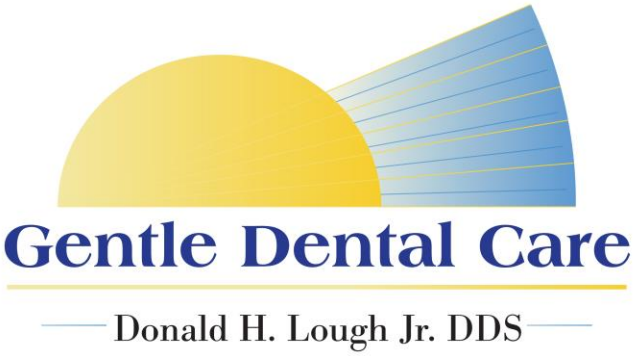
_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that 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 _____



Dear Patient,

You may not be aware that dental insurance rarely covers the entire cost of any major procedure. As hard as we try, it is not possible to know what your insurance plan covers. There are many insurance companies and hundreds of plans within each company. We strongly urge you to call your insurer if you have questions regarding coverage by your particular plan. There should be a phone number or web address on your insurance card.

Insurance plans often change annually. It is up to you to know your coverage. You are financially responsible for any and all work your insurance considers patient responsibility.

Signature_____Date_____