Lesley K. Gilbert DDS
Family and Cosmetic Dentistry

Welcome

Thank you for choosing our practice for your dental needs. Date: _______________

Please complete this two-page form. You may print it out and fill in your answers in ink, or you may input your answers directly on the form on your computer. If you are hand-writing, please print.

If you have any questions or concerns, do not hesitate to ask — we will be happy to help.

Patient Information

Name: ____ Social Security Number: ________________
Address: ____ City: ______________ State: ___ Zip: _______
Home Phone: (___) ________ Work Phone: (___) ________ Cell Phone: (___) ________
Email: ____
Birth Date: ______________________ Sex: Female Male
How do you prefer to hear from us? Phone: Home Work Cell Email Text No preference
Marital Status: Single Married Divorced Widowed
Employer/School: __________________________________ Occupation: ___________________________
Employer/School Address: ____________________________ City: ______________ State: __ Zip: ______
Spouse or Parent's Name: ____
Employer: ____ Work Phone: (___) ________
Person to contact in case of emergency: __________________________________ Phone: (___) ________
Whom may we thank for referring you to us? ____

Responsible Party Information

Name of person financially responsible for this account: ____
Relationship to patient: __________________________________ Phone: (___) ________
Address: ____ City: ______________ State: ___ Zip: _______
Employer: ____ Work Phone: (___) ________

Insurance Information

Name of Insured: _________________________________ Relationship to patient: ___________________
Birth Date: ______________________ Social Security Number: ________________
Employer: ____ Work Phone: (___) ________
Address: ____ City: ______________ State: ___ Zip: _______
Insurance Co.: ___________________________Group #: _________ Contract/ID #: __________________
Insurance Co. Address: _____________________________ City: ______________ State: ___ Zip: _______
DO YOU HAVE ADDITIONAL INSURANCE? No Yes If yes, please complete the following section:
Name of Insured: _________________________________ Relationship to patient: ___________________
Birth Date: ______________________ Social Security Number: ________________
Employer: ____ Work Phone: (___) ________
Address: ____ City: ______________ State: ___ Zip: _______
Insurance Co.: ___________________________Group #: _________ Contract/ID #: __________________
Insurance Co. Address: _____________________________ City: ______________ State: ___ Zip: _______

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Dental History

Former dentist & location: ______________________________ Date of last exam: ______________

Reason for today's visit/chief complaint: ____

How often do you brush? ____________________ How often do you floss? ____________________

Please check any of the following conditions that apply to you:

Bad breath	Grinding teeth	Tooth sensitivity to heat
Bleeding gums	Loose teeth or broken fillings	Tooth sensitivity to sweets
Clicking/popping jaw, TMJ pain	Periodontal disease/treatment	Tooth sensitivity when biting
Food collects between teeth	Tooth sensitivity to cold	Sores or growths in your mouth

Are you happy with the appearance of your teeth? Yes No

Have you ever had any serious trouble associated with any previous dental treatment? Yes No

Medical History

Physician & location: ______________________________________ Date of last visit: ______________

Please list all medications and supplements you are currently taking (include non-prescription & herbal):

____

Allergies: ____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have or have had any of the following:

AIDS/HIV positive	Circulatory problems	Hernia repair	Shortness of breath/respiratory problems
Anemia	Congenital heart lesions	High blood pressure	Sinus problems
Arthritis, rheumatism	Cortisone treatments	HIV positive	Skin rash
Artificial heart valve	Diabetes	Jaw pain	Stomach problems
Artificial joint	Epilepsy	Kidney trouble	Stroke
Asthma	Fainting	Low blood pressure	Swelling of feet/ankles
Back problems	Glaucoma	Mitral valve prolapse	Thyroid problems
Bleeding abnormally	Headaches	Nervous problems	Tobacco habit how much? ____________
Blood disease	Heart murmur/valve problems	Pacemaker	Tonsillitis
Bowel problems/ulcerative colitis/C-diff	Heart problems describe: ________________	Psychiatric care	Ulcer/hyperacidity
Cancer	Hemophilia	Radiation treatment	Vaping/e-cigarette use how much? ____________
Chemical dependency	Hepatitis/jaundice	Recreational drug use	Venereal disease
Chemotherapy		Respiratory disease	
		Sexually transmitted disease	

Any condition(s) not listed here:

____

Have you ever taken any of these medications?

Diet medications:	Dexfenflurmine	Fen-phen	Pondimin	Redux
Blood thinners:	Coumadin	Warfarin	Other	

Doctor's signature: ____ Date: ______________________

Certification and Assignment of Benefits

To the best of my knowledge, the information I give here is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health. I certify that I and/or my dependents have insurance coverage with and assign directly to Lesley K. Gilbert, DDS, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Lesley K. Gilbert, DDS, LLC and assignees may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The undersigned agrees that all past-due amounts shall be charged 1.75% interest per month on the unpaid balance commencing thirty (30) days after billing and accepts full responsibility and agrees to notify this office with 10 days of any change of address. In the event that your account must be turned over for collection, the undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us (collection agency fees can be up to an additional 50% of the amount turned over for collection) and agrees to pay reasonable attorney fees, court costs, and other costs paid or incurred by this office or our collection agency while collecting the amount due.

Signature: ____ Date: ______________________

Print name: ____