Welcome to our Practice!

Cosmetic · Restorative · Implant · Sedation

DENTISTRY by

Greg L. Gist D.D.S.

Denistry for the Quality Conscious

Thank you for taking the time to complete this comprehensive patient profile.
It's designed to help us get to know you – and your dental needs.

We're glad you're here!

PATIENT INFORMATION

Name (Last, First, MI) _____ E-Mail _____

Marital Status _____ Date of Birth _____ Soc. Sec. # ____-____-____ Driver's Lic. # _____

Street _____ City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____

Your Employer _____ Your Occupation _____

Your Spouse's Name _____ Spouse's Occupation _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

Who is responsible for payment? ___ Relationship _____ Phone # _____

Whom may we thank for referring you to us? _____

Psalm 121:1-2 *"I will lift mine eyes into the hills, from whence cometh my help. Thy help cometh from the Lord, which made heaven & earth."*

HEALTH HISTORY

Your Physician - Dr. _____ Phone # or City _____

Other Doctor(s) - Dr. _____ Phone # or City _____

1. How long since you have had a dental exam? _____ Cleaning? _____
2. Are you having pain or discomfort at this time ☐ Head ☐ Neck ☐ Gums ☐ Tooth ☐ _____
3. Do you have TMJ or head/neck pain? ☐ Yes ☐ No
4. Are you dealing with high stress or anxiety in your life? ☐ Yes ☐ No
5. Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
6. Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
7. Are you interested in Sedation Dentistry? ☐ Maybe ☐ Yes ☐ No
8. Have you been a patient in the hospital in the last two years? ☐ Yes ☐ No
9. Have you been under the care of a medical doctor in the last two years? ☐ Yes ☐ No
10. Have you taken any medicine/drugs in the last two years? *(Please list current meds below.)*

    Drug Name _____ Dosage _____ Reason _____

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11. Have you ever had an allergic reaction to any medication *(i.e. itching, rash, etc.)*? ☐ Yes ☐ No
    If yes, what medication do you use to prevent/control this? _____ ☐ Yes ☐ No
12. Have you ever been made sick by medication? If yes, which one? _____ ☐ Yes ☐ No
13. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
14. When you walk up stairs or take a walk, do you have to stop because of pain in your chest, shortness of breath or because you are very tired? ☐ Yes ☐ No
15. Are you on a special diet? If yes, what kind? _____ ☐ Yes ☐ No
16. Has your doctor ever said that you have cancer or a tumor? ☐ Yes ☐ No
17. Do you smoke? ☐ Yes ☐ No Smokeless tobacco? ☐ Yes ☐ No
18. Female: Are you pregnant now? ☐ Yes ☐ No Practicing birth control? ☐ Yes ☐ No

Circle any of the following you have had or have now:

AIDS or HIV+
Allergies to Antibiotics
Allergies to Latex
Allergies to Penicillin
Allergies to Sulpha Drugs
Allergies - Other
Anemia
Arthritis
Artificial Joint
Asthma
Autoimmune Disorders
Blood Transfusion
Bruise Easily
Cancer(s)
Chemotherapy
Chronic Cough
Chronic Headaches
Cold Sores
Cortisone Medicine
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Fainting or Dizzy Spells
Glaucoma
Heart Attack
Heart Defibulator
Heart Disease
Heart Failure
Heart Lesion (congenital)
Heart Mitral Valve Prolapse
Heart Murmur
Heart Pace Maker
Heart Surgery
Heart Valve (artificial)
Hemophilia
Hepatitis A (infectious)
Hepatitis B (serum)
Hepatitis C
High Blood Pressure
Hives
Jaw Joint Pain
Kidney Trouble
Liver Disease
Migraine Headaches
Nervousness
Neurological Disease(s)
Psychiatric Treatment
Radiation Treatments
Scarlet Fever
Sinus Trouble
Stroke
Syphilis or Gonorrhea
Thyroid Disease
Tuberculosis
Ulcers
Venereal Diseases

Do you have a current condition or diagnosis not mentioned here? _____

SMILE EVALUATION

1. Do you have any concerns about your teeth or smile? ☐ Yes ☐ No

2. How do you feel about the way your smile looks?

   _____

   _____

   ☐ I love my smile!
   ☐ My smile is okay.
   ☐ I don't like my smile.
   ☐ I hate my smile-HELP!

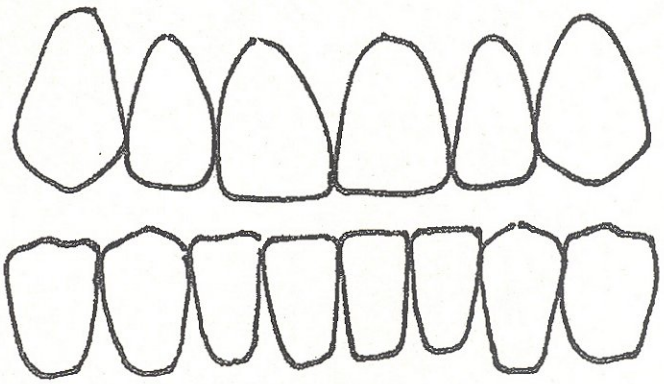
3. If you could change anything about your teeth/smile, what would it be?

   _____

   _____

   _____

   ☐ Color corrections
   ☐ Spaces closed
   ☐ Crowding relieved
   ☐ Shape & size correction
   ☐ Too much gum showing
   ☐ Bite problems
   ☐ Dark metal fillings show



Sometimes it's easier to show us - go ahead and doodle!

Did you know that Periodontal disease is painless? It affects 87% of the population — and The victims may be unaware that it's happening to them. But don't wait until it hurts! There ARE warning signs:

1.	Do your gums bleed when you brush, floss or toothpick between your teeth?	☐ Yes	☐ No	☐ Sometimes
2.	Are your gums red, swollen or tender?	☐ Yes	☐ No	☐ Sometimes
3.	Are your gums pulling away from your teeth?	☐ Yes	☐ No	☐ I don't know
4.	Do you see pus between your teeth and gums when you press against them?	☐ Yes	☐ No	☐ Sometimes
5.	Are your permanent teeth loose or separating?	☐ Yes	☐ No	☐ I don't know
6.	Is there any change in the way your teeth fit together when you bite?	☐ Yes	☐ No	☐ I don't know
7.	Is there any change in the fit of your partial denture?	☐ Yes	☐ No	
8.	Do you have bad breath?	☐ Yes	☐ No	

As a part of your visit today, we will assess your gum tissue and periodontal health — and recommend what's needed to keep your gums healthy, non-surgically. We are "passionate" about keeping you free from any infection, large or small!

Rom.15:13 *"Now the God of hope fill you with all joy and peace believing, that ye may abound in hope, through the power of the Holy Ghost..."*

OUR FINANCIAL POLICY

Thank you for choosing us for your dental health care. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign at your first appointment.

- ☐ **Full payment is due at time of service.**
- ☐ **We accept cash, checks, VISA, MasterCard and Discover.**
- ☐ **We offer an extended payment plan(s) through a financial institution with prior credit approval.**

INSURANCE — We are pleased to complete and submit all necessary forms to your insurance company for processing. We will also assist you with any questions or disputes that often arise with insurance companies. However, we do not accept "assignment of benefits". What this means is that we expect payment at time of service (above). Once processed, your insurance reimbursement will then go directly to you.

MINORS — The adult accompanying a minor is responsible for payment at time of service. For unaccompanied minors, non-emergency treatments will be denied unless arrangements for payment have been made prior to the visit. All adults accompanying a minor are asked to remain in the waiting room during treatment.

MISSED APP'TS — Our practice is not a high volume practice. The time scheduled for you is just for you. If you miss an appointment, we do not have another patient scheduled for this time. Please help us serve you in the best way by keeping scheduled appointments. We ask for a 24-hour notice for any cancellations or an office visit charge may otherwise be assessed.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We are all here to care for you. God bless you!

To the best of my knowledge, the answers in this profile are correct and true. Also, I have read the above Financial Policy and understand and agree to these conditions.

Signature of Patient or Responsible Party _____ Date _____

Matthew 6:32-33 — *"For your heavenly father knoweth that ye have need of all these things. But seek ye first the kingdom of God and His righteousness; and all these things shall be added unto you."*