Better and Gentle Family Dentistry
150 Hurley Avenue
Kingston, NY 12401
845.339.0964
www.dentistinkingston.com

Patient Information Sheet

Date:

Patient Information

First Name:	Last Name:	MI:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Gender: / Marital Status:	DOB:	SSN:
Email:		
Employed By:		
Person Responsible for this Account:		
Person to Contact In Case of Emergency:	Phone:	
Referred by:		

Dental Insurance/Primary (Policy Holder)

First Name:		Last Name:			MI:
Address:					
City:		State:		Zip:	
DOB:	SSN:	Patient's Relationship To Policy Holder:	☐ Self ☐ Spouse ☐ Child ☐ Other		
Name of Insurance:					
Group #:		Effective Date:		Calendar Year:	
P:	B:	M:	Ded:	Max:	Ortho:

Dental Insurance/Secondary (Policy Holder)

First Name:		Last Name:			MI:
Address:					
City:		State:		Zip:	
DOB:	SSN:	Patient's Relationship To Policy Holder:	☐ Self ☐ Spouse ☐ Child ☐ Other		
Name of Insurance:					
Group #:		Effective Date:		Calendar Year:	
P:	B:	M:	Ded:	Max:	Ortho:

Patient History

Frequencies

Cleaning/ Exams:	Bitewings:	Pan/ FMX:
Sealants:	Fluoride:	Deep Cleaning:

Dental History

Do you have, or have you had? (If Yes, please Explain)

	Present dental problems?
	Any serious problem associated with dental treatments?
	Tooth sensitivity:
	Clench or grind teeth:
	Any loose teeth?
	Jaws ache when you awake in the morning?
	Are you satisfied with the appearance of your teeth?
	Have you had orthodontic therapy?
	Prior periodontal therapy?

Medical History

Physician's Name:	Date of Last Physical:

	Have you tested positive for COVID-19?								
	Are you currently under a physician's care?								
	Have you had any serious illnesses?								
	Have you ever been a patient in the hospital?								
	Are you taking any medications, and for what?								
	Do you have any allergies?								
	Have you ever had local anesthesia?								
	Heart Disease		Rheumatic Fever		Abnormal Blood Pressure		Ulcers		Hepatitis A B C
	Diabetes		Epilepsy		Anemia		Congenital Heart Disease		Blood Disorders
	Thyroid Disease		Infectious Disease		Abnormal bleeding following a cut?		Frequent or Severe Headaches?		Do you smoke?
	Heart Murmur		Asthma or Hay Fever		Sinus Trouble		TB or Lung Disease		Jaundice
	Arthritis		Stroke		Glaucoma		Nervous Disorder		Venereal Disease
	Kidney/Liver problems		HIV/Aids		Do you get short of breath after climbing stairs?				
	Do you get pains in your chest over your heart?				Do your ankles swell during the day?				
	Do you have any disease or medical problem that is not listed on this form? If so, please explain:								

Women only:

	Are you pregnant?		Are you on birth control pills?		Have you reached menopause?		Are you taking any hormones?

Appointment Cancellation Policy

- $25.00 for appointments cancelled without 24 hour advanced notice.
- $50.00 for not showing up for your appointment and not calling us to let us know.

To the best of my know ledge, I have answered every question completely and accurately. I will inform my Dentist or Hygienist of any changes in my health or medication.

Signature:	Date:

Print First Name:	Print Last Name:	Relationship to Patient: ☐ Self ☐ Child ☐ Guardian