CHARLES F. GABET, D.D.S.

GALEN R. WILLIAMS, D.D.S.

WELCOME

GABET FAMILY DENTISTRY, LLC

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name ______________ ______________ ____ Soc. Sec. # ______________
Last Name First Name Initial

Address ______________________________

City ______________ State ________ Zip ________ Phone ______________

Sex ❑ M ❑ F Age ____ Birthdate ____________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by ______________________ Occupation ______________

Bus. Address ______________________ Bus. Phone ____________ Cell Phone ____________

Whom may we thank for referring you? ______________________________

Name in case of emergency ______________________ Phone ______________

Name of spouse ______________________ Spouses place of employment ______________

PRIMARY INSURANCE

Person Responsible for Account ______________ ______________
Last Name First Name

Relation to Patient ______________ Birthdate ____________ Soc. Sec. # ______________

Address(if different from patient) ______________________________

City ______________ State ________ Zip ________ Phone ______________

Person Responsible Employed by ______________________ Occupation ______________

Bus. Address ______________________ Bus. Phone ____________ Cell Phone ____________

Insurance Company ______________________________

Contact # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________________________

PATIENT INFORMATION

Former Dentist________________ Address________________

Date of last Dental Care________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

____

Other information about your dental health or previous treatment________________

MEDICAL HISTORY

Physician Name________________ Address________________ Phone________________

Date of last visit________________ Have you ever had any serious illness or operation? ❑ Y ❑ N

If yes, Please describe________________________________

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates________________

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Any allergies to medication?________________________________

Medicine currently taking________________________________

Check ✓ if you have/had any of the following:

❑ Aids
❑ Anaphylaxis
❑ Anemia
❑ Arthritis rheumatism
❑ Artificial heart valves
❑ Artificial joints
❑ Asthma
❑ Back problems
❑ Blood disease
❑ Cancer
❑ Chemical dependency
❑ Chemotherapy
❑ Circulation problems
❑ Cortisone treatments
❑ High blood pressure
❑ Cough, persistent
❑ Cough up blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Food allergies
❑ Glaucoma
❑ Headaches
❑ Heart murmur
❑ Heart problems Describe________________
❑ Hemophilia
❑ Herpes
❑ Hepatitis
❑ Rheumatic fever
❑ HIV positive
❑ Jaw pain
❑ Kidney disease or malnutrition
❑ Liver disease
❑ Material allergies (latex, wool, metal, chemicals)
❑ Mitral valve prolapse
❑ Nervous problems
❑ Osteoporosis
❑ Pacemaker
❑ Psychiatric care
❑ Rapid weight gain or loss
❑ Radiation treatment
❑ Scarlet fever
❑ Shortness of breath
❑ Skin rash
❑ Sleep apnea
❑ Spina bifida
❑ Stroke
❑ Surgical implant
❑ Swelling of feet or ankles
❑ Thyroid disease
❑ Tobacco habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer
❑ Venereal disease

AUTHORIZATION

I authorize the Dentist to release any information including the diagnosis and the records of any treatment rendered to me during the period of such dental care to third party payers and/or other health practitioners. I hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or on behalf of my dependants. To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or if my medication changes, I will inform Gabet Family Dentristy, LLC at my next appointment. That in the event of my default payment to Gabet Family Dentistry, LLC as I have agreed. I agree to allow Gabet Family Dentistry, LLC to file any and all legal proceedings in Steuben County, Indiana. I further understand that I will be responsible for any out of pocket expenses, including resonable costs for collection and attorney's fees. I further understand in the event of my default regarding payment, that Gabet Family Dentistry, LLC, will release information regarding my account to an attorney and or collection agency of choice.

Signature________________________________ Date________________