

Welcome!

New Patient Information



Gary Nack, DDS FAGD
120 Buck Rd
Holland, PA 18966
215-364-6540
www.gnackdds.com

About You

Name: _____
I prefer to be called: _____
Home Address: _____

Married Single Divorced Widowed

Birthdate: _____ Age: _____
Social Security #: _____
Email: _____
Home #: _____
Work #: _____
Cell #: _____
Drivers License #: _____
Employer: _____
Employer Address: _____

Occupation: _____

Where & when is the best time to reach you?

Whom may we thank for referring you?

Previous/Present Dentist: _____
Last Visit Date: _____

Spouse Information

His/Her Name: _____
Employer: _____
Work #: _____ SS#: _____
Birthdate: _____

Person Responsible for Account:

Name: _____
Work #: _____ Home #: _____
Billing Address: _____
Relation: _____ SS#: _____
Employer: _____
Birthdate: _____ DL# _____

Insurance Information

Primary Coverage:

Dental Coverage: _____ Yes No
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
Group #: _____
Insured's Name: _____
Insured's Birthdate: _____
Insured's SS#: _____
Insured's Employer: _____
Relationship: _____

Secondary Coverage:

Dental Coverage: _____ Yes No
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
Group #: _____
Insured's Name: _____
Insured's Birthdate: _____
Insured's SS#: _____
Insured's Employer: _____
Relationship: _____

Medical History

Do you have a personal physician? _____ Yes No
Physician's Name: _____
Phone #: _____
Date of last visit: _____
Are you currently under the care
of a physician? _____ Yes No
Please explain: _____

Your current physical health is: (*circle one*)
Good Fair Poor

Are you taking any prescription/over-the-counter or
herbal supplement drugs? _____

Have you ever taken Fosamax, or any other
bisphosphonate or osteoporosis medication?
Yes No

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

- Y N Abnormal Bleeding
- Y N Alcohol/Drug Abuse
- Y N Allergies
- Y N Anemia
- Y N Arthritis
- Y N Artificial Bones/Joints/Valves
- Y N Asthma
- Y N Blood Transfusion
- Y N Bypass Surgery
- Y N Cancer
- Y N Chemotherapy
- Y N Colitis
- Y N Congenital Heart Defect
- Y N Diabetes
- Y N Difficulty Breathing
- Y N Emphysema
- Y N Epilepsy
- Y N Fainting Spells
- Y N Fever Blisters
- Y N Frequent Headaches
- Y N Glaucoma
- Y N Hay Fever
- Y N Heart Attack
- Y N Heart Disease
- Y N Heart Murmur
- Y N Heart Surgery
- Y N Hemophilia

- Y N Hepatitis A
- Y N Hepatitis B
- Y N Hepatitis C
- Y N Herpes
- Y N High Blood Pressure
- Y N HIV / AIDS
- Y N HPV
- Y N Kidney Disease
- Y N Kidney Stones
- Y N Liver Disease
- Y N Low Blood Pressure
- Y N Mitral Valve Prolapse
- Y N Osteoporosis
- Y N Pacemaker/Defibulator
- Y N Psychiatric Problems
- Y N Radiation Therapy
- Y N Rheumatic Fever
- Y N Scarlet Fever
- Y N Seizures
- Y N Sexually Transmitted Disease
- Y N Shingles
- Y N Sickle Cell Disease/Traits
- Y N Sinus Problems
- Y N Stroke
- Y N Thyroid Problems
- Y N Tuberculosis (TB)
- Y N Ulcers

Please list any serious medical condition(s) or hospitalizations that you have ever had:

Dental History

Why have you come to the dentist today?

Are you allergic to any of the following?

- Y N Aspirin
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Jewelry
- Y N Latex
- Y N Metals
- Y N Penicillin
- Y N Tetracycline

Please list any other drugs/materials that you are allergic to: _____

For Women

- Are you using a prescribed method of birth control? Yes No
- Are you pregnant? Yes No
- If yes, week #: _____
- Are you nursing? Yes No

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Do your gums ever bleed? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Do you now or have you ever experience pain/discomfort in you jaw joint (TMJ) Yes No

Your current dental health is: *(circle one)*

Good Fair Poor

Do you like your smile? Yes No

Would you like whiter teeth? Yes No

Fresher Breath? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? *(circle one)*

Soft Medium Hard

Do you smoke or use tobacco in any other form? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. ***I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.***

Signature

Date

Relationship to Patient (if a minor)

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

Signature

Date

Relationship to Patient (if a minor)

Anesthesia Consent

I, the undersigned patient, hereby give my consent for Dr. Gary Nack to administer an anesthetic prior to a dental procedure in order to achieve local anesthesia. I have agreed to the use of the anesthetic(s)** listed below to achieve the desired anesthetic affect.

I understand the risks inherent in anesthesia. I have discussed these risks with the dentist and acknowledge that they include, but are not limited to: allergic reaction, infection, bleeding, phlebitis (irritation of vein), nausea, blood clots, loss of limb function, paralysis, parasthesia, stroke, heart attack, brain damage, or death.

I give permission for the undersigned provider and any of his/her qualified associates to administer the anesthetic.

I have been given the opportunity to ask questions and express concerns I have about the anesthesia. The undersigned provider has answered my questions and addressed my concerns.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

** local anesthetics used by this office

4% Prilocaine plain

4% Articaine w 1:200000 epi

3% Mepivacaine plain

2% Mepivacaine w 1:20000 levonordefrin

2% Xylocaine w 1:100000 epi

Signature

Date

Relationship to Patient (if a minor)

I have read the above and request that no local anesthesia be used during my treatment.

Signature

Date

Relationship to Patient (if a minor)

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctors Comments: _____
