Mark Gilbert
Family Dentist

662-895-0100
8947 College St.
Olive Branch, MS 38654

Patient Registration and Medical History

(Please Print)

Date: _____

Patient: _____ Preferred Name _____

Date of Birth: _____ Age: _____ Male - Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell: _____

Work: _____ Other: _____

Which option would you prefer to be reached by to confirm your dental appointment? (Please circle one) Call cell or home Text

Employed By:

_____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse Employed By: _____ PHONE: _____

Your SSN: _____- _____-_____ Spouse's SSN: _____-_____-_____

Primary Dental Insurance: _____

Policy Holders Name: _____

Secondary Dental Insurance: _____

Policy Holders Name: _____

In Case of an Emergency: _____ Phone: _____

Whom may we thank for referring you? _____

Date of your last dental cleaning: _____

Are you having any dental problem? _____

(Women) Are you pregnant? _____ _____

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Medical History

Physician's Name _____

Phone Number: _____

Are You Under The Care of a Physician? _____If so, for what condition: _____

Do You Have Any of The Following? (Check or Circle the Boxes that apply To You)

_____ Acid Reflux	**_____ Epilepsy**	**_____ Seizures**
_____ Arthritis	**_____ Headaches/Migraine**	**_____ Sinus**
_____Artificial Joints	**_____ Heart Attack**	**_____ Smoker**
_____ Asthma	**_____ Heart Stents**	**_____ Smokeless Tobacco**
_____ Back Problems	**_____ Heart Valves**	**_____ Stroke**
_____ Bi-Pass Surgery	**_____ Hepatitis A, B or C**	**_____ Tuberculosis**
_____ Blood Disease	**_____ High Blood Pressure**	
_____ Blood Thinner	**_____ HIV+ or AIDS**	
_____ Cancer	**_____ Jaundice / Liver Disease**	
_____ Diabetes	**_____ Radiation Treatment**	
_____Drug/Alcohol Dependent	**_____ Respiratory Disease**	

Have Any Drug/Medication Allergy?

_____Aspirin ____ Ceclor _____ Codeine _____ Dental Anesthetic _____ Erythromycin
_____ Keflex _____ Latex _____ Penicillin _____ Sulfur

Other: _____

Are you taking any medications? _____ if so, please list on the following attached sheet.

I understand that I'm responsible for all charges for a services provided. If insurance applies I understand that I'm responsible for any remaining unpaid balances. I also understand it is my full financial responsibility to pay all court cost, fees and/or any attorney fees if my account is turned over for collections. As service to our patients, we will file charges for services to the insurance companies. However, we do consider the patient responsible for the account. When payment of insurance claim is assigned to us that estimated portion of the fee which is payable by the patient is due at the time of service.

Date: _____ Signature: _____

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Acknowledgment of Privacy Notice

I, _____, have been informed about the copy of this Office Notice of the Privacy Practice. Stating that my dental information will not be given out to anyone without my permission.

Signature: _____ Date: _____

List of Medication

Medication Name	Dosage and Milligram	Reason
Example: Aspirin	**1 time day 81mg**	**stroke**