Harry A. Gentry, D.D.S.
3585 Lawrenceville-Suwanee Road, Ste. #101
Suwanee, GA 30024

Welcome! We will do our best to make your time with us as pleasant as possible. Please fill in the following information completely and return to the front desk. Thank you.

Date_____ Home #_____ Cell #_____

Patient Name_____

D.O.B._____ Marital Status: S M D W SS#_____

Gender: M F E-mail address_____

Address_____

City/State/Zip_____

Occupation_____ Employer_____

Work phone_____

IF PATIENT IS A MINOR: Parent's Name_____

Full-time student: School_____ City/State_____

Is family member or relative a patient seen in our office? Yes_____ No_____

Name_____ Relationship_____

How did you learn about our practice? _____
_____Referred by Doctor_____
_____Referred by family member_____
_____Referred by friend_____

CONSENT FOR TREATMENT

- I hereby authorize Dr. and/or designated staff to take x-rays, study models, photographs, and any other diagnosis aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs.
- Upon such diagnosis, I authorize the Dr. to perform all the recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.
- I understand that using anesthetic agents embodies certain risks.
- I being the parent/guardian do hereby request and authorize the dental staff to perform the necessary dental services for my child, including but not limited to x-rays and the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

Signature of patient, parent or responsible party_____ Date_____

Person to contact in case of emergency_____

Relationship_____ Home #_____ Cell #_____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____SS#_____DOB_____

Primary Carrier_____Group#_____

Primary Carrier Address_____

Primary Carrier Phone #_____

FINANCIAL POLICIES

I understand that:

- Full payment is due at time of service and/or that portion that insurance does not cover in your plan.
- All charges are ultimately the responsibility of the patient/guarantor (regardless of insurance).
- Any fees quoted in this office's treatment plans will be honored for 6 months.
- In the event payment is not made by the due date, a late charge and/or a rebilling fee may be applied to the patient's account.
- The patient/guarantor is responsible to pay for all services rendered on their behalf if insurance does not pay within 60 days of the date of service.
- This office makes no guarantee of the insurance payment as estimated. Any fees not covered by insurance is the patient/guarantor's responsibility to pay. Acceptance of insurance assignment of benefits to this office does not absolve the patients of full responsibility of payment for treatment rendered.
- Any estimate given by this office regarding insurance portions is only a guideline until the final insurance payment is received and the patient's account has been reconciled.
- This office as a courtesy to the patient will file your insurance claims. Any patient/guarantor whose insurance carrier does not honor assignment of benefits to the provider of service must pay this office at the time of service rendered.

I certify that I have read and do hereby agree to the above stated financial policies of this office.

Patient/Guarantor_____Date_____

MEDICAL HISTORY

Physicians Name_____Last physical_____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING:

__Heart problems	__Tuberculosis	__Epilepsy	Allergic to:
__Heart murmur	__Headaches	__Anemia	__Anesthetics
__Mitro valve prolapse	__Asthma	__Diabetes	__Codeine
__Rheumatic fever	__Hepatitis	__Arthritis	__Penicillin
__Bleeding problems	__Aids (or other immune suppressive disorders)		__Latex
__High blood pressure	__Major surgery of any kind		__Other allergies

Do you need to take antibiotics before dental care?_____If yes, why?_____
Are you taking any drugs or medication now?_____
Are you currently under the care of a physician?_____
Have you been hospitalized in the last year?_____If yes, why?_____
Please describe any other medical problems we should be aware of:_____
Are you having discomfort in your mouth now?_____
Do your gums bleed?_____ Do you grind or clench your teeth?_____Does your jaw pop, click or hurt?____
What is your impression of your health? **POOR FAIR GOOD** Date of last dental visit_____
Women only: Are you pregnant?_____
Is there any information we need to know that would assist us in your treatment?_____
_____