Welcome

Stephen Michel, DMD
Greg Bottone, DMD

Gentle Family Dentistry

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help. Thank you for choosing our practice for your dental needs.

Patient Information (Confidential)

Name__________ Name Preferred__________ Date __________

Social Security #__________ Birthdate__________ Home Phone__________ Cell Phone __________

Address__________ City __________ State__________ Zip __________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married E-mail Address: __________

If student, Name of School/College__________ City__________ State__________ Zip__________

Patient's or Parent's Employer__________ Work Phone __________

Business Address__________ City__________ State__________ Zip__________

Spouse or Parent's Name__________ Employer __________ Work Phone __________

Whom May We Thank For Referring You?__________

Person to Contact in Case of Emergency __________ Phone __________

Responsible Party

Name of Person Responsible for the Account__________ Home Phone __________

Address __________ Relationship to Patient__________

Driver's License #__________ Birthdate__________ Social Security # __________

Employer __________ Work Phone __________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Are there any other family members that you would like to add to the same account?__________

Patient Name__________

Insurance Information

Name of Insured __________ Relationship to Patient __________

Birthdate__________ Social Security # __________ Name of Employer__________

Insurance or Company__________ Group # __________ Effective Date __________

Consent for Services

As a condition of your treatment by our office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

In order to avoid broken appointment fees, please give 24 hours notice.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, we cannot render services on the assumption that our charges will be paid by an insurance company. After 60 days, unpaid dental claims will be the patient's responsibility.

A service fee of 1 1/2% per month (18% per annum) will be charged on all accounts exceeding 60 days.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. I authorize insurance claims submitted on my behalf.

__________ Date:__________ Relationship to Patient:__________

Signature of patient, parent or guardian

__________ Date:__________ Relationship to Patient:__________

Signature of guarantor of payment/responsible party

Gentle Family Dentistry

MichelandBottone.com
924 Tall Pine Road, Suite B • Mt. Pleasant, SC 29464
smiles@michelandbottone.com
(843)884-4486

Patient Name: ______________ Last ______________ First ____ MI

______________ Preferred Name

Medical Infomation

If Female, are you currently:

☐ Pregnant, or trying to get pregnant ☐ Breastfeeding ☐ Using any type of Birth Control

Are you currently using any of the following?

☐ Ciggarettes, Cigars, Pipe ☐ Smokeless Tobacco Products ☐ Vape Pen ☐ Controlled Substances

Please check all that apply:

☐ Alzhiemers	☐ Anemia	☐ Anxiety Disorders	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Bi Polar Disorder	☐ Blood Disease	☐ Cancer	☐ Dementia
☐ Depression	☐ Diabetes Type I	☐ Diabetes Type II	☐ Dizziness/Fainting	☐ Drug Addiction
☐ Emphysema	☐ Epilepsy	☐ Excessive Bleeding	☐ Glaucoma	☐ Growths/Tumors
☐ Hay Fever	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Hypoglycemia	☐ Intestinal/Digestive Disease	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Multiple Sclerosis	☐ Osteoperosis	☐ Pacemaker
☐ Parkinson's Disease	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Sinus Problems	☐ Sleep Apnea
☐ Stroke	☐ Thyroid Disease	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease
☐ Migraines	☐ Pacemaker	☐ Sinus Problems		

Are you allergic to or have you had any reactions to the following:

☐ Latex ☐ Sulfa Drugs ☐ Penicillin or any other antibiotics ☐ Aspirin
☐ Any Metals (Nickel, mercury, etc) ☐ Local Anesthetics ☐ Sedatives ☐ Pain Meds

Any Conditions or Diagnosis not present above? If yes, please explain.

____

____

Do you require Antibiotic Pre Medication prior to dental appointments?

☐ Yes ☐ No

List all medications (prescription and non-prescription), Please include regular dosages of aspirin.

____

____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature ______________________________

Date ______________________________

Response Date: __________

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PATIENT RECORDS REQUEST FORM

Name of Patient Whose Record is Requested ______________________________

DOB ______________________ Phone (_____)________________________

Address____

City/State/Zip____

Name of Doctor to Contact for Records__________________________________

City/State/Zip____

Phone (______)______________________

Please provide a copy of record and most recent x-rays for patient indicated above. Thank you for your time and effort to forward these records in a timely manner.

Signature of Patient or Parent____________________ Date ________________

Gentle Family Dentistry

Cancellation and Missed Appointment Policy

Our goal is to provide quality dental care for all of our patients. Broken appointments and late cancellations inconvenience our other patients who need to schedule in a timely manner. We would like to inform you of our office policy regarding missed appointments.

Cancellation of an Appointment

Please be courteous and call the office promptly if you are unable to make an appointment. We require that you call at least 24 hours in advance. An earlier cancellation will give another patient the opportunity to come in sooner.

How to Cancel Your Appointment

To cancel an appointment, please call (843)884-4486. If you do not reach our front desk staff, you may leave a detailed message on our voice mail and we will contact you to reschedule.

Late Cancellations

A late cancellation is when a patient fails to cancel their appointment without a 24 hour notice.

Broken Appointment

A broken appointment is when a patient misses an appointment without calling to cancel. Our office will charge a fee for late cancellations and broken appointments. The fee may vary depending on the type of appointment.

Please sign below to acknowledge that you have read and understand the office policy. Thank you for your understanding and cooperation.

___________________________________ ___________________________

Signature Date