JP

PROSTHODONTICS

IMPLANT · ESTHETIC · RESTORATIVE DENTISTRY

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

**PATIENT INFORMATION**

Last Name Middle Initial First Name

Name:_____

Date of Birth:_____Male_____Female _____

Address:_____Unit Number:_____

City:_____State:_____Zip Code:_____

Minor_____Single_____Married_____Divorced_____Widowed_____

Social Security Number:_____-_____-_____

Whom may we thank for referring you?:_____

**PERSONAL PHONE NUMBERS**

Best phone number to be contacted:_____

Please circle: Home Work Cell Other

Please provide a secondary phone number:_____

Person to Contact in case of Emergency:_____

Relation:_____Phone Number:_____

**INSURANCE INFORMATION**

Primary Carrier:_____

Claims Mailing Address:_____

Employer:_____Employee Name:_____

Relation to Patient:_____Date of Birth:_____

Member ID:_____Group Number:_____

Secondary Carrier:_____

Claims Mailing Address:_____

Employer:_____Employee Name:_____

Relation to Patient:_____Date of Birth:_____

Member ID:_____Group Number:_____

Please note that the above information regarding your dental insurance is most important to our billing office. Please be certain that all information is complete as misinformation can result in unnecessary delay in insurance reimbursement. Also, please remember that you, as the patient, are solely responsible for the services rendered, regardless of your insurance coverage. If for some reason we have not received payment from your insurance carrier within 60 days, we expect you to personally settle the outstanding balance within 30 days.

## DENTAL/ MEDICAL HISTORY

Main reason for Today's Visit:_____
Date of last Dental Visit/ Dental X-Ray?_____
How often do you floss? _____How often to you brush?_____

**Please circle if you have had any of the following:**

Bad Breath Teeth Grinding Sensitivity to…. Heat Sweets Biting Cold
Dry Mouth Bleeding Gums Loose Teeth or Broken Fillings Braces
Clicking or popping Jaw Gum Disease/ Treatment
Food Collection between Teeth Sores or Growths in your mouth

How do you feel about your smile?:_____
Are you experiencing and dental pain or discomfort:_____

***Please mark with an "X" if applicable***

_____AIDS/ HIV positive
_____Alzheimer's Disease
_____Anaphylaxis
_____Anemia
_____Angina
_____Arthritis/ Gout
_____Artificial Heart Valve
_____Artificial Joint
_____Asthma
_____Blood Disease
_____Blood Transfusion
_____Breathing Problems
_____Bruise Easily
_____Cancer
_____Chemotherapy
_____Chest Pains
_____Cold Sores Fever Blisters
_____Congenital Heart Disorder
_____Convulsions
_____Diabetes
_____Drug Addiction
_____Emphysema
_____Epilepsy or Seizures
_____Excessive Bleeding
_____Excessive Thirst
_____Fainting Spells/ Dizziness
_____Frequent Cough
_____Frequent Headaches
_____Glaucoma
_____Hay Fever
_____Heart Attack/ Failure
_____Heart Murmur
_____Heart Pacemaker
_____Heart Trouble/ Disease
_____Hemophilia
_____Hepatitis A
_____Hepatitis B or C
_____Herpes
_____High Blood Pressure
_____High Cholesterol
_____Hives or Rash
_____Hypoglycemia
_____Irregular Heartbeat
_____Kidney Problems
_____Leukemia
_____Liver Disease
_____Low Blood Pressure
_____Lung Disease
_____Mitral Valve Prolapse
_____Osteoporosis
_____Pain in Joints
_____Psychiatric Care
_____Radiation Treatments
_____Recent Weight Loss
_____Renal Dialysis
_____Rheumatism
_____Scarlet Fever
_____Shingles
_____Sickle Cell Disease
_____Sinus Trouble
_____Stomach/ Intestinal Disease
_____Stroke
_____Swelling of Limbs
_____Thyroid Disease
_____Tonsilitis
_____Tuberculosis
_____Tumor or Growths
_____Ulcers
_____Veneral Disease

## MEDICAL HISTORY

Has a physician or dentist recommended you take antibiotics prior to your dental visit? Y N
Artificial (prosthetic) heart valve Y N Previous Infective Endocarditis Y N
Damaged valves in transplanted heart Y N Congenital Heart Disease Y N

Have you had any serious illness or operation? Y N *please explain* _____
_____
Are you taking any medications? _____
_____
Have you ever taken Fosamax, Bonita, Actonel or any other medications containing bisphosphonate for osteoporosis? Y N
Are you currently under a physician's care? Y N *please explain*_____
Have you ever had a serious head or neck injury? Y N *please explain*_____
Are you on a special diet?: Y N *please explain*_____
Do you use tobacco/ Cannabis?: Y N Do you use controlled substances?: Y N

**Women: Are you…**
_____Pregnant/ Trying to get pregnant? _____Taking Oral Contraceptives? _____Nursing?

**Are you allergic to any of the following?:**
_____Latex _____Penicillin/ Antibiotics _____Acrylic _____Local Anesthetics
_____Metal _____Aspirin _____Sulfa Drugs_____Codeine/ Narcotics
_____Barbiturates, sedatives or sleeping pills? _____Iodine Other_____

**AUTHORIZATION AND RELEASE**
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
I authorize and request my insurance company to pay directly to the dentist or dental group in insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submission._____Initials

***Payment is due in full at the time of treatment unless prior arrangements have been approved.***

_____ _____
**Signature of Patient or Guardian** **Date**

_____ _____
**Doctor's Signature** **Date**