

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 dental pain or discomfort: _____

Please mark with an "X" if applicable

_____ AIDS/ HIV positive	_____ Hepatitis A
_____ Alzheimer's Disease	_____ Hepatitis B or C
_____ Anaphylaxis	_____ Herpes
_____ Anemia	_____ High Blood Pressure
_____ Angina	_____ High Cholesterol
_____ Arthritis/ Gout	_____ Hives or Rash
_____ Artificial Heart Valve	_____ Hypoglycemia
_____ Artificial Joint	_____ Irregular Heartbeat
_____ Asthma	_____ Kidney Problems
_____ Blood Disease	_____ Leukemia
_____ Blood Transfusion	_____ Liver Disease
_____ Breathing Problems	_____ Low Blood Pressure
_____ Bruise Easily	_____ Lung Disease
_____ Cancer	_____ Mitral Valve Prolapse
_____ Chemotherapy	_____ Osteoporosis
_____ Chest Pains	_____ Pain in Joints
_____ Cold Sores Fever Blisters	_____ Psychiatric Care
_____ Congenital Heart Disorder	_____ Radiation Treatments
_____ Convulsions	_____ Recent Weight Loss
_____ Diabetes	_____ Renal Dialysis
_____ Drug Addiction	_____ Rheumatism
_____ Emphysema	_____ Scarlet Fever
_____ Epilepsy or Seizures	_____ Shingles
_____ Excessive Bleeding	_____ Sickle Cell Disease
_____ Excessive Thirst	_____ Sinus Trouble
_____ Fainting Spells/ Dizziness	_____ Stomach/ Intestinal Disease
_____ Frequent Cough	_____ Stroke
_____ Frequent Headaches	_____ Swelling of Limbs
_____ Glaucoma	_____ Thyroid Disease
_____ Hay Fever	_____ Tonsillitis
_____ Heart Attack/ Failure	_____ Tuberculosis
_____ Heart Murmur	_____ Tumor or Growths
_____ Heart Pacemaker	_____ Ulcers
_____ Heart Trouble/ Disease	_____ Veneral Disease
_____ Hemophilia	

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