PATIENT INFORMATION

Date: _____

First Name:_____ MI:____ Last:_____ Preferred:_____

Birth Date:_____ Age:_____ SS#:_____ Sex: M F

Cell Phone:_____ Work Phone:_____EXT_____ Home Phone:_____

Which is the best Number/Time to reach you? _____ Text/Email reminders?_____

Address:_____City:_____ State:_____ Zip:_____

Email:_____ □ Married/Partnered □ Widowed □ Single □ Minor

Emergency Contact:_____ Relationship:_____Phone:_____

Who may we thank for referring you?_____

DENTAL INSURANCE INFORMATION

PRIMARY

Insurance Company_____

Customer Service Phone Number_____

Employer_____

Group Name_____Group Number_____

Subscriber_____ DOB_____

Subscriber/Member ID/SSN_____

Relationship to Patient _____

SECONDARY

Insurance Company_____

Customer Service Phone Number_____

Employer_____

Group Name_____Group Number_____

Subscriber_____ DOB_____

Subscriber/Member ID/SSN_____

Relationship to Patient _____

DENTAL HISTORY

Date of last dental visit: _____

Name of your previous dentist: _____

Reason for your visit today: _____

Have you ever had an oral cancer screening? Y N

How often do you brush? _____

How often do you floss? _____

Have you/family member ever been treated for periodontal disease? Y N

Have you ever had complications from an extraction? Y N

Have you ever had popping/clicking near your ear when you chew? Y N

Are you prone to frequent headaches? Y N

Do you grind/clench your teeth? Y N

Do you have □ Sores □ Blisters □ Loose/Broken fillings

□ Dry Mouth □ Food Collection □ Bleeding Gums

□ Mouth Breathing □ Nail Biting □ Chew on one side

Swollen/Tender □ Gums □ Lips □ Cheeks

Have you ever had Orthodontic treatment? Y N

Do you snore? Y N

Do you have problems with bad breath? Y N

Have you ever had an allergic reaction to:

□ crown

□ metal filling

□ dental appliance

Have you ever used an Power Toothbrush? Y N

Waterpik? Y N

Are your teeth sensitive to □ Hot □ Pressure

□ Cold □ Sweets

On a scale of 1-10 (10 highest), Please indicate how important your dental health is to you.

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be?

□ Whiter

□ Close space

□ Replace dark fillings with tooth colored restorations

□ Repair Chipped teeth

□ Replace Missing teeth

□ Replace old crowns that don't match

PATIENT HEALTH HISTORY

	Y	N
AIDS/HIV	□	□
Allergies_____	□	□
Anemia	□	□
Arthritis	□	□
Artificial HeartValves	□	□
Asthma	□	□
Blood Disease	□	□
Cancer _____	□	□
Chemical Dependency	□	□
Chemotherapy	□	□
Circulatory Problems	□	□
Cortisone Treatments	□	□
Cough, persistent	□	□
Diabetes	□	□

	Y	N
Emphysema	□	□
Epilepsy/Seizures	□	□
Excessive Bleeding	□	□
Fainting/Dizziness	□	□
Glaucoma	□	□
Headaches	□	□
Hearing Impaired	□	□
Heart lesions	□	□
Heart Murmur	□	□
Heart Problems	□	□
Hepatitis _____	□	□
Herpes	□	□
High Blood Pressure	□	□
Jaundice	□	□

	Y	N
Jaw Pain	□	□
Joint Replacement	□	□
Kidney Disease	□	□
Liver Disease	□	□
Low Blood Pressure	□	□
Mitral Valve Prolapse	□	□
Neck/Back Problems	□	□
Nervous Problems	□	□
Pacemaker	□	□
Psychiatric Care	□	□
Radiation Treatment	□	□
Respiratory Problems	□	□
Rheumatic Fever	□	□
Scarlet Fever	□	□

	Y	N
Shortness of Breath	□	□
Sinus Problems	□	□
Skin Rash	□	□
Stroke	□	□
Swollen Feet/ankles	□	□
Swollen Neck glands	□	□
Thyroid Disease	□	□
Tonsillitis	□	□
Tuberculosis	□	□
Tumor/Growths	□	□
Ulcers	□	□
Venereal Disease	□	□
Weight change,un-explained	□	□

MEDICAL QUESTIONS

List any Medications you are taking - include nonprescription drugs:_____
_____
_____
_____

Are you allergic to □ Penicillin □ Local Anesthesia
□ Latex □ Sulfa □ Barbiturates
□ Iodine □ Aspirin □ Codeine
□ Other_____

Are you in good health? Y N

Date of last medical exam _____

Have you ever been hospitalized? Y N
if yes, please explain_____

Pharmacy_____

Do you have any disease/problem that we should know about? Y N
_____
_____

Have you had a transplant operation that has depressed your immune system? Y N

Have you had an allergic reaction to bananas? Y N

Do you smoke or use tobacco? Y N

Have you had Heart surgery? Y N

Are you currently under the care of an MD? Y N

Are you/have you ever taken bisphosphonates? Y N
(Fosamax or Actonel for osteoporosis, chemotherapy, etc)

Women: Are you Pregnant or Nursing? Y N
Taking birth control? Y N

Insurance Assignment and Release

I certify that I and/or my dependents have insurance coverage with the aforementioned insurance company(ies) and assign directly to Dr Jackson all insurance benefits if otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr Jackson may use my healthcare information and may disclose such information to the above named insurance company(ies) and there agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will remain in effect until I revoke it in writing.

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or other members of his staff responsible for any errors that I have made in the completion of this form.

Patient:_____ Date:_____

Parent/Guardian (if patient is a minor)_____ Date_____