JACKSON FAMILY DENTISTRY

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____

Home Address: _____ Martial Status_____

City: _____ State: _____ Zip Code: _____

_____

Social Security #:_____ Email: _____

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

Employer: _____ Employer Phone: _____

Occupation: _____

Spouse Name: _____ Date of Birth: _____

How did you hear about our office: _____

Reason for visit: _____

Person Financially Responsible for Account: _____

Home Address: _____

Phone Number: _____ Cell: _____

Employer: _____ Employer Phone: _____

Social Security Number: _____ Date of Birth _____

Dental Insurance Information (Primary Carrier)

Insured Name: _____ Date of Birth _____

Insured Address: _____

Home Phone: _____ Cell Phone: _____ SS# _____

Employer: _____ Employer Phone: _____

Insurance Company: _____

Insurance Address: _____

Subscriber/Member ID: _____ Group # _____

Dental Insurance Information (Secondary Carrier)

Insured Name: _____ Date of Birth _____

Insured Address: _____

Home Phone: _____ Cell Phone: _____ SS# _____

Employer: _____ Employer Phone: _____

Insurance Company: _____

Insurance Address: _____

Subscriber/Member ID: _____ Group # _____

When was your last dental visit? _____

What was done at that time? _____

Are you comfortable during dental procedures? _____

In not please explain: _____

Do you usually have local anesthetic (Novocaine) for dental work? _____

Have you had periodontal treatment (gum surgery)? _____

HEALTH HISTORY

This medical history is important for your safety, and will assist us in caring for any special needs.

Family Physician_____Phone #_____
Address_____

Do you have a current medical problem?_____
If yes, please describe_____

Please list any medications you are currently taking_____

Male_____ Female_____

Women: Are you pregnant?_____ If yes, how many months?_____

Name/Phone # of person to call in case of an emergency:_____
Relationship_____

Have you ever had (please circle):

Heart Disease	Yes	No	Artificial Heart Valve	Yes	No
Heart Murmur	Yes	No	Artificial Joints	Yes	No
Rheumatic Fever	Yes	No	Bleeding Problems	Yes	No
Diabetes	Yes	No	Venereal Disease	Yes	No
Arthritis	Yes	No	Cancer or Tumors	Yes	No
Asthma	Yes	No	AIDS/HIV	Yes	No
Hepatitis	Yes	No	Kidney/Liver Problems	Yes	No
High Blood Pressure	Yes	No	Allergies	Yes	No
Do you use Tobacco?	Yes	No	Reactions to Medications	Yes	No
			Which Ones?_____		

Have you ever been hospitalized or had a serious illness?_____
If yes, please explain._____

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (or legal guardian)_____Date:_____

Date:_____Dentist Signature_____