JONES DENTAL CLINIC

Welcome

Please take a few minutes to fill out the information below before your first visit, so we may better serve you upon your arrival.

Patient Name_____ I prefer to be called_____ Today's date ___/___/_____

M [ ] F [ ] Single [ ] Married [ ] Child [ ] Other [ ] Birthdate___/___/____ SS # _____-_____-_____

Home Address_____City_____State___ Zip_____

Home Phone (___)_____Work (___)_____Cell (___)_____

Email_____Employer_____Occupation _____

Do you have Dental Insurance? Y [ ] N [ ] **If yes, please bring your insurance card/information with you.**

Responsible Party_____DOB_____ SS # _____-_____-_____

Former Dentist_____ City/State_____

Date of last dental visit_____ Date of last dental x-rays_____

Medical History

Physician's name_____City/Phone_____ Date of last visit_____

Please check all that apply:

[ ] AIDS/HIV
[ ] Anemia
[ ] Arthritis, Rheumatism
[ ] Artificial Heart Valves
[ ] Artificial Joints
[ ] Asthma
Use Inhaler Y [ ] N [ ]
[ ] Bleeding abnormally w/ extractions or surgery
[ ] Blood Thinners
[ ] Breathing problems
[ ] Cancer, type_____
[ ] Chemotherapy, When_____
[ ] Congenital heart lesions
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting/Dizziness
[ ] Fever Blisters/Cold sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Murmur
[ ] Heart Pace Maker
[ ] Heart Surgery
[ ] Hepatitis, Type_____
[ ] High Blood Pressure
[ ] Kidney Disease
[ ] Liver Disease
[ ] Radiation Treatment When_____
[ ] Respiratory Disease
[ ] Rheumatic Fever
[ ] Sickle Cell Disease
[ ] Stroke
[ ] Surgical Shunt
[ ] Tobacco Use
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease

*Explain_____

Women: Are you Pregnant Y [ ] N [ ] Nursing Y [ ] N [ ] Taking birth control pills Y [ ] N [ ]

Medications

List any medications you are currently taking
And Correlating diagnosis _____
_____

Allergies

[ ] Aspirin [ ] Latex [ ] Metals
[ ] Codine [ ] Penicillin [ ] Erythromycin
[ ] Dental Anesthetics [ ] Sulfa [ ] Other_____

I authorize and give consent to perform dental services to Jones Dental Clinic. I certify to the accuracy of the above statements regarding my medical and dental history. Payments for all treatment and services rendered are my responsibility.

_____ _____ _____
Signature of patient, parent, guardian or personal representative | Printed name of patient, parent, guardian or personal representative | Date

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.
I understand that I may ask questions I might have regarding this notice.

_____ _____
Signature | Date