Patient Information

Name _____ Soc. Sec. #_____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone_____

E-mail _____

Sex M ❑ F ❑ Age _____ Birth date _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorce

Patient Employed by _____ Occupation _____

Who may we thank for referring you? _____

Notify in case of emergency _____ Phone _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Date of last dental care _____ Date of last x-ray _____

Check (✓) Yes or No if you have had problems with any of the following:

❑ Y ❑ N Bad breath	❑ Y ❑ N Food collection between teeth	❑ Y ❑ N Periodontal treatment	❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Bleeding gums	❑ Y ❑ N Grinding or clenching teeth	❑ Y ❑ N Sensitivity to cold	❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Clicking or popping jaw	❑ Y ❑ N Loose teeth or broken fillings	❑ Y ❑ N Sensitivity to hot	❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

PHYSICIAN _____ DATE OF LAST PHYSICAL EXAM _____

DESCRIBE ANY CURRENT MEDICAL TREATMENT (SURGERIES) **INCLUDING DRUGS TAKEN** _____

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

_____ ALLERGIES TO DRUGS/OTHER_____
_____ ALLERGIES TO ANESTHETIC_____
_____ HEART AILMENTS _____ HEART ATTACK _____ MURMUR
_____ PACEMAKER _____ ANGINA _____ BIRTH DEFECT
_____ HIGH BLOOD PRESSURE _____ LOW BLOOD PRESSURE
_____ NEUROLOGICAL PROBLEMS
_____ ASTHMA
_____ ARE YOU TAKING ASPIRIN? _____
_____ DIABETES
_____ KIDNEY PROBLEMS
_____ ULCER _____ COLITIS _____ INTESTINAL DISEASE
_____ ARE YOU PREGNANT
_____ ARTIFICIAL JOINT OR VALVE REPLACEMENTS
_____ PSYCHIATRIC CARE
_____ STROKE

_____ HEPATITIS _____ JAUNDICE _____ LIVER DISEASE
_____ AIDS _____ HIV INFECTION _____
_____ VENEREAL DISEASE
_____ CANCER / MALIGNANCIES
_____ EXCESSIVE BLEEDING FROM A CUT
_____ ANEMIA OR BLOOD PROBLEMS
_____ ARTHRITIS
_____ RHEUMATIC FEVER
_____ SINUS PROBLEMS
_____ THYROID
_____ TUBERCULOSIS
_____ RESPIRATORY DISEASE
_____ FAINTING SPELLS _____ SEIZURES
_____ EYE DISORDERS
_____ RADIATION TREATMENT

ARE YOU WEARING CONTACT LENSES_____ DO YOU SMOKE _____ IF YES, HOW MUCH _____

I certify that I have read the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his / her staff, responsible for any errors or omissions I may that have made in the completion of this form.

PATIENT SIGNATURE: _____ **DATE:** _____
(If under 18, parent or guardian must sign)

REGARDING COPAYS & PAYMENTS

To avoid misunderstandings regarding dental insurance, the amount quoted for copays is an ESTIMATE ONLY. The patient is responsible for knowing their own insurance copays and limitations. The staff at Jefferson Dental will assist you by filing all claims and predeterminations. All quotes are estimates, pending insurance approval and payment. Your contract is with your insurance company. It is the patient's responsibility for balances not paid by insurance. By signing this form, you are agreeing to abide by the terms of our office policies and procedures.

NO SHOW AND CANCELLATION POLICY

If a scheduled appointment is not kept or cancelled at least 24 hours before the scheduled time, you will be required to pay a missed appointment fee. Presently the fee is $200 per hour for a doctor and $50 an hour for a hygienist. This fee is not covered by your insurance. You will be required to pay it out of pocket. (This fee will be waived in cases of legitimate emergencies.)

Appointments are often scheduled months ahead. Please mark your appointment times on your calendar. Our office will call you to remind you of your appointment two business days before your scheduled time. If you have an appointment with the hygienist, you will also receive a postcard to remind you. We will make every effort to either reach you or leave a message for you. Please inform us if your phone number or address changes.

JEFFERSON DENTAL ASSOCIATES, LTD.

ACKNOWLEDGMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I,_____, have received or reviewed a copy of

Jefferson Dental Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

I, _____, fully understand the contents of your office policies and procedures and agree to abide by them. I also understand and agree to pay for the changes that may be made towards my account for dental services rendered by this office, consistent with the terms of my dental insurance policy. I hereby authorize JEFFERSON DENTAL ASSOCIATES, LTD., To furnish information to my insurance company regarding myself or my dependents.

_____ _____

Signature of patient/parent/guardian Date