PATIENT INFORMATION RECORD

Welcome to our office!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

Jones FAMILY DENTISTRY

REGISTRATION

Name	☐ Male ☐ Female
Address	Date of Birth
City State ZIP	Home Phone
Occupation	Email
Employer	Business Phone
Cell Phone Cell Provider (needed for appointment reminder texts only): -Standard text messaging rates from your carrier apply-	
Spouse's Name Date of Birth	Occupation
Spouse's Employer	Business Phone
Name of Close Relative or Friend	Phone
Person Responsible for Account	Relationship
Do you have dental insurance? ☐ Yes ☐ No Does your spouse have dental insurance? ☐ Yes ☐ No	
Whom may we thank for referring you to our office?	

MEDICAL HISTORY

Clinic/Physician's Name	Phone
Clinic Address	Women: Are you pregnant? ☐ Yes ☐ No
Explain if you are currently under a physician's care, or if there is any information about your health we should know:	
Please list all medications (including birth control pills):	
Please list all allergies to any medications or chemicals: (Penicillin, Codeine, Latex, Sulfa, etc.):	
Do you require dental pre-medication? ☐ Yes ☐ No	
Any abnormal bleeding problems? ☐ Yes ☐ No	Have you ever had a blood transfusion? ☐ Yes ☐ No
Do you use tobacco products? ☐ Yes ☐ No	If yes, would you like to quit? ☐ Yes ☐ No

Please circle all that apply to you:

				High Blood Pressure
Heart Disease/Angina	Arthritis	Glaucoma	Cancer/Radiation Tx	Heart Murmur
Joint Replacement	Anemia	Allergies	Mental Illness	Sexually Transmitted Disease
Mitral Valve Prolapse	Stroke	Hearing Loss	Contact Lenses	Digestive Disorder
Hemophilia	Asthma	Sinus Trouble	Epilepsy/Seizures	Emphysema/Bronchitis
Rheumatic Fever	Tuberculosis	AIDS/HIV/ARC	Hepatitis (A, B, or C)	Alcoholism/Chem Dependency
Stomach Ulcer	Diabetes	Thyroid Trouble	Kidney Disease	Artificial Heart Valve

Updates:

_____ _____ _____ _____ _____ _____

Initials, Date Initials, Date Initials, Date Initials, Date Initials, Date Initials, Date

OVER, PLEASE

Jones Family Dentistry

DENTAL HISTORY

When was your last dental visit?	What was done?
Who was your former dentist?	Date of last full mouth x-rays:
Have you ever had any serious trouble in previous dental visits? ☐ Yes ☐ No If yes, please explain:	
Do you have any pain or discomfort in your mouth? ☐ Yes ☐ No If yes, please explain:	
Have you had any previous periodontal work (Gum Treatment)? ☐ Yes ☐ No When was your last treatment?_____	
Do you wear full or partial dentures? ☐ Yes ☐ No When were they made?	
Have you had orthodontic treatment (Braces)? ☐ Yes ☐ No	Do you clench or grind your teeth? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE

Policy Holder Name	Birthdate
Relationship to Patient	Social Security #
Address (If different from pt)	Insurance Co Name
	Address
Employer	Insurance ID# Group#

SECONDARY DENTAL INSURANCE

Policy Holder Name	Birthdate
Relationship to Patient	Social Security #
Address (If different from pt)	Insurance Co Name
	Address
Employer	Insurance ID# Group#

AUTHORIZATION

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature of Patient/Parent Date

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge this document authorizes my dentist to submit claims for benefits to Jones Family Dentistry for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of Covered Person/Employee Signature of Covered Person/Employee

Please sign below if you would like text message appointment reminders, email appointment notification, or both:
(to prevent blocked messages, please be sure to add reminder@jonesfamilydentist.com to your contact list or address book).

_____ _____ Circle: **EMAIL** **TEXT** **BOTH**

Signature Date