Jones Creek
FAMILY DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ☐M ☐F Married: ☐Y ☐N

Work Phone_____ Cell Phone_____Email_____

If patient is under 18 yrs, please also complete the following:

Guarantor *Name*_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ☐M ☐F Married: ☐Y ☐N

Work Phone_____ Cell Phone_____Email_____

Student status if dependent over 19 (for ins) ☐Nonstudent ☐Fulltime ☐Part time

How did you hear about us? (Please be specific so we can thank them!)_____

_____

ADDRESS AND HOME PHONE

Check circle if same for entire family: ☐

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Patient relationship to subscriber: ☐Self ☐Spouse ☐Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber: ☐Self ☐Spouse ☐Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:_____

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
* If sent to collections, I agree to pay a **$30 collection fee**, all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None

_____

_____

_____

_____

Check medications or drugs you are allergic to:

- ☐ None
- ☐ Aspirin
- ☐ Codeine/ Other Narcotics
- ☐ Erythromycin
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other: _____

Check any medical conditions you may have:

☐ None	☐ Diabetes	☐ Joint Replacement, Date of: _____
☐ AIDS/HIV	☐ Emphysema	☐ Kidney/Bladder Trouble
☐ Alcohol/Drug Abuse	☐ Epilepsy	☐ Liver Disease
☐ Anemia/Leukemia	☐ Fainting Spells/Seizures	☐ Low Blood Pressure
☐ Anorexia/Bulimia	☐ Fever Blisters/Herpes	☐ Mental Health Problems
☐ Arthritis	☐ Frequent Headaches	☐ Mitral Valve Prolapse
☐ Asthma/Hay Fever	☐ Frequently Dry Mouth/Sjogren	☐ Persistent Diarrhea
☐ Blood Clotting Problems	☐ Gall Bladder Trouble	☐ Rheumatic Fever
☐ Blood Transfusion	☐ Heart Attack/Stroke	☐ Rheumatic Heart Disease
☐ Bronchitis	☐ Heart Disease/Angina	☐ Sexually Transmitted Disease
☐ Cancer/Tumor or Growth	☐ Heart Murmur	☐ Sinus Trouble
☐ Cardiac Pacemaker	☐ Hepatitis/Jaundice	☐ Stomach Ulcers
☐ Chest Pain Upon Exertion	☐ High Blood Pressure	☐ Thyroid Problems
☐ Damage Heart Valve	☐ Hives/Skin Rash	☐ Tuberculosis

☐ Other: _____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? ☐Yes / ☐No

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit:_____ Are you in pain? Yes / No

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Name (printed) Date

_____

Patient/Guardian Signature