

# Welcome

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.

## ABOUT YOU

Today's Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_ ☐ Male ☐ Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
APT/CONDO #:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated  
CITY STATE ZIP

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Driver's License #: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## INSURANCE COVERAGE

### PRIMARY

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### SECONDARY

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

In the event of an emergency, is there someone  
who lives near you that we should contact?

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**CONTINUED ON BACK**

# MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: \_\_\_\_\_

Are you taking any prescriptions / herbal supplements? ☐ Yes ☐ No

Please list each one: \_\_\_\_\_

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

Do you or have you ever taken Fosamax, Actonel, or Boniva?

☐ Yes ☐ No If yes, indicate how long: \_\_\_\_\_

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol / Drug Abuse	Y N Herpes / Fever Blisters
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+ / AIDS
Y N Artificial Bones / Joints / Valves	Y N Hospitalized for Any Reason
Y N Asthma	Y N Kidney Problems
Y N Blood Transfusion	Y N Liver Disease
Y N Cancer / Chemotherapy	Y N Low Blood Pressure
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Pacemaker
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Emphysema	Y N Rheumatic / Scarlet Fever
Y N Epilepsy	Y N Seizures
Y N Fainting Spells	Y N Shingles
Y N Frequent Headaches	Y N Sickle Cell Disease / Traits
Y N Glaucoma	Y N Sinus Problems
Y N Hay Fever	Y N Stroke
Y N Heart Attack	Y N Thyroid Problems
Y N Heart Murmur	Y N Tuberculosis (TB)
Y N Heart Surgery	Y N Ulcers
Y N Hemophilia	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Metals
Y N Codeine	Y N Jewelry	Y N Penicillin
Y N Dental Anesthetics	Y N Latex	Y N Tetracycline
Y N Sulfa		

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

# DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids or foods? ☐ Yes ☐ No

Have you had any head, neck or jaw injuries? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

What would you change about your smile? \_\_\_\_\_

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you want to be sedated for dental treatment? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

By signing below, I give permission to Dr. Jarrell and her staff to provide treatment to the above named patient. I accept full financial responsibility for the treatment performed by this office. Insurance forms will be completed as a convenience to the patient; however, payment to the doctor is expected for any co-payment and deductibles that my insurance does not cover for services rendered. A service charge of 1.5% per month (**annual percentage rate 18%**) will be added to all past due accounts. Any account over 30 days past due is subject to a minimum service charge of \$10.00 per month. Should the services of an outside agency be required for collection of this account, I agree to pay reasonable attorney's fees, court costs, and other costs of collection. There will be an automatic surcharge of 30% of patient balance for any balance owed to account for collection fees. I authorize you to check my credit from any and all sources.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_