JAX DENTAL STUDIO

Today's Date:_____

Patient Name:_____
Last **First** **Middle**

Date of Birth:_____ **Social Security No:**_____

Home Address:_____
Street **City** **State** **Zip Code**

Phone Numbers:_____
Preferred contact: ☐ **Home** ☐ **Work** ☐ **Cell**

E-mail Address:_____

Marital Status: __**Single** __**Married** __**Widowed** __**Divorced** **Spouses Name:**_____

Full Time Student: ___ **Yes** ___ **No** **Name of School:** _____

Employer:_____
Name of Company **Position**

Who may we thank for referring you to our office? _____

Medical History

- ☐ **Heart Disease**
- ☐ **Rheumatic Fever**
- ☐ **Heart Murmur/MVP**
- ☐ **Valve Replacement**
- ☐ **High Blood Pressure**
- ☐ **Low Blood Pressure**
- ☐ **Abnormal Bleeding**
- ☐ **Tuberculosis**
- ☐ **Osteoporosis/Osteopenia**
- ☐ **Asthma**
- ☐ **Sinus Trouble**
- ☐ **Epilepsy**
- ☐ **Headaches**
- ☐ **Depression**
- ☐ **Stroke**
- ☐ **Kidney Disease**
- ☐ **Jaundice/ Hepatitis**
- ☐ **Ulcers**
- ☐ **Intestinal Disorder**
- ☐ **Diabetes/ Abnormal Blood Sugar**
- ☐ **Tumors or Cancer**
- ☐ **Radiation Treatment**
- ☐ **Chemotherapy**
- ☐ **AIDS/HIV Positive**
- ☐ **Arthritis**
- ☐ **Joint Replacement**
- ☐ **Organ Replacement**

Are you allergic to:__**Penicillin** __**Codeine** __**Latex** __**Novocaine** __**Other**_____

Please list all medications that you are presently taking:

Name	**Dose**	**Times per day**

Do you use tobacco? __ **Yes or** __ **No** **If yes, how often?**_____
Have you been hospitalized in the past year? __ **Yes or** __ **No**
Who is your primary care physician? _____
Do you have any other medical or previous surgical condition of which we should be aware?

_____
_____

Consent for Treatment

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary and advisable, including the use of local anesthetics as indicated. I understand that certain procedures may lead to post-operative discomfort, sensitivity or temporary numbness.

Patients (Parents) Signature:_____ **Date:**_____

Dental History

1. **Are you concerned about any special dental problem now?** _____
2. **Are you having pain or discomfort?** _____
3. **How long has it been since your last dental visit?** _____
4. **Are you satisfied with the appearance of your teeth?** _____
5. **Has there been a change in color or position of your teeth?** _____
6. **Are your teeth sensitive to:** ____**Pressure** ____**Sweets** ____**Cold** ____**Hot**
7. **Do you consider that you get many cavities?** _____
8. **Does food catch or wedge between your teeth?** _____
9. **Do you have any loose teeth?** _____
10. **Do your gums bleed easily?** _____
11. **Are you aware of a bad taste or odor in your mouth?** _____
12. **Have you ever been told that you have gum disease or pyorrhea?** _____
13. **Do you grit or clench your teeth?** _____
14. **Do your jaws or neck ever feel sore?** _____
15. **What do you think of the condition of your mouth?** _____
16. **Please list any questions you would like to have answered.**

_____

Financial Information

(IF RESPONSIBLE PARTY IS OTHER THAN PATIENT)

Person responsible for payment: _____ **Relationship to patient:**_____

Home Address: _____
Street **City** **State** **Zip Code**

Business Address: _____
Street **City** **State** **Zip Code**

Phone Numbers: **Home:**_____ **Business:**_____

I agree to be responsible for payment of all services rendered in addition to collection expenses and/or attorney fees if necessary. If covered by insurance Dr. Brotman will estimate co-payment amounts and file claims on my behalf. I understand that the difference between the actual fee and the amount paid by insurance is my responsibility.

Responsible Party Signature:_____ **Date:**_____

Insurance Information

	Policy #1	Policy #2
Subscriber Name (Insured)		
Insured SSN or ID Number		
Employer Name		
Group Number		
Insurance Company Name		
Patients Relationship to Insured		