FAMILY JT DENTAL

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD

≈≈ABOUT YOU≈≈

Today's Date:_______________ SS#: ________________________________

Name:____
Last First Middle Name

I prefer to be called: ___________________________ Birthdate:______/______/______ Age: ______ ☐Male ☐Female

Home Address: ____
City State Zip Code

Email Address: ____

Home #: (______)___________________Cell #: (______)______________________Work #: (______) ___________________

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Partner

Employer:____Address: ____

Whom may we thank for referring you? ____

Previous/Present Dentist:____________________________________Phone #:___________________Last Visit Date: ___________

≈≈INSURANCE INFORMATION≈≈

PERSON RESPONSIBLE FOR ACCOUNT: ____

Relationship:________________________ Birthdate:________/________/________ SS #: ____________________________

Employer:____

Billing Address: ____

Home #: (_______)____________________Work #: (________) _______________________

PRIMARY INSURANCE Dental Coverage ☐YES ☐NO

Insurance Co. Name:____Phone:___________________

Insured 'sName:_____________________Relation:__________________Insured's Employer: ______________________________

Group # (Plan, Local, Policy):__________________________SS#_________________________Insured's Birthday____/____/____

SECONDARY INSUREANCE Dental Coverage ☐YES ☐NO

Insurance Co. Name:____Phone:___________________

Insured 'sName:_____________________Relation:__________________Insured's Employer: ______________________________

Group # (Plan, Local, Policy):__________________________SS#_________________________Insured's Birthday____/____/____

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PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
SIGNATURE **DATE**

CANCELLATION POLICY

I have been informed of JT Family Dental's cancellation policy. I agree to pay a $50 cancellation fee if I do not provide 24 hours notice or failure to attend appointment.

≈≈ DENTAL HISTORY≈≈

WHY HAVE YOU COME TO THE DENTIST TODAY? ____________________

Are you currently in pain? ☐YES ☐NO   Do you require antibiotics before dental work? ☐YES ☐NO

≈≈ MEDICAL HISTORY≈≈

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT: ____________________

Physician's Name:____________________Phone: ____________________

Are you currently under the care of a physician? Why?____________________

Date of Last visit:__________   Your current physical health is ☐Good ☐Fair ☐Poor

Do you have a history of smoking or using tobacco products? ☐YES ☐NO

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐YES ☐NO

Have you had a heart valve replacement or total joint replacement? ☐YES ☐NO

Please list any prescription, over-the-counter or herbal supplement drugs you are taking?

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

Y N	Abnormal Bleeding/Hemophilia	Y N	Epilepsy	Y N	Mitral Valve Prolapse
Y N	Alcohol/Drug Abuse	Y N	Fainting Spells	Y N	Pacemaker
Y N	Anemia	Y N	Glaucoma	Y N	Psychiatric Problems
Y N	Arthritis	Y N	Hay Fever	Y N	Radiation Treatment
Y N	Artificial Bone/Joints/Valves	Y N	Heart Attack/Surgery	Y N	Rheumatic Fever
Y N	Asthma	Y N	Heart Murmur	Y N	Scarlet Fever
Y N	Blood Transfusion	Y N	Hepatitis	Y N	Seizures
Y N	Cancer/Chemotherapy	Y N	Herpes/Fever Blisters	Y N	Shingles
Y N	Colitis	Y N	High Blood Pressure	Y N	Sickle Cell Dis./Traits
Y N	Congenital Heart Defect	Y N	Hospitalized for any reason	Y N	Sinus Problems
Y N	Diabetes	Y N	Kidney Problems	Y N	Stroke
Y N	Difficulty Breathing	Y N	Liver Disease	Y N	Thyroid Problems
Y N	Dizziness	Y N	Low Blood Pressure	Y N	Tuberculosis (TB)
Y N	Emphysema	Y N	Lupus	Y N	Ulcers
Y N	Frequent Headaches	Y N	Trouble falling asleep	Y N	Wake Rested
Y N	Ringing in ears	Y N	Trouble staying asleep		

Please list any serious medical conditions that you have ever had: ____________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metal	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

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

FOR WOMEN: Are you using birth control? ☐YES ☐NO Pregnant? ☐YES ☐NO Due:__________Nursing? ☐YES ☐NO

Anything you would like to discuss with the dentist in private? ☐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.

____

SIGNATURE   **DATE**

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