JACKSON SQUARE
DENTISTRY

To meet all your healthcare needs, please fill out this form completely and accurately.

Patient Information (CONFIDENTIAL)

Name_____Birthdate_____ SS#_____
HomePhone_____CellPhone_____Address_____
_____City_____State_____Zip/P.C._____-
Email_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
If Student, Name of School/ College_____City_____State____ ☐ Full time ☐ Part time
Patient or Parent/Guardian's Employer_____WorkPhone_____
Business Address_____City_____State_____Zip/P.C._____
Spouse or Parent/Guardian's Name_____Employer_____Work Phone_____
How did you hear about our office?_____
Person to contact in case of emergency_____

It is customary to pay in full, at the time of service, for services rendered. Check the payment option you prefer.
☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ AMEX ☐ Care Credit ☐ Flex Spending Account

Responsible Party

Name of Person Responsible for this Account_____Relationship to Patient_____

Insurance Information

Name of Insured_____Relationship to Patient_____
Birthdate_____SS#/SIN_____ Name of Employer_____Date employed _____
Insurance Company_____Group #_____Policy/ ID#_____
Ins. Co. Address_____City_____State_____Zip/P.C._____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No
Name of Insured_____Relationship to Patient_____
Birthdate_____SS#/SIN_____ Name of Employer_____Date employed _____
Address of Employer_____City_____State_____Zip/P.C._____
Insurance Company_____Group #_____Policy/ ID#_____
Ins. Co. Address_____City_____State_____Zip/P.C._____

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet/sour foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficulty with extractions in the past?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you ever had orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	☐	☐
Do you like your smile?	☐	☐

Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness with the last 5 years? If yes please explain_____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____ _____		
4. Have you ever taken Fen-Phen/ Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
➢Local Anesthetics (e.g. Novocain)	☐	☐
➢Penicillin or any other Antibiotics	☐	☐
➢Sulfa Drugs	☐	☐
➢Barbiturates	☐	☐
➢Sedatives	☐	☐
➢Iodine	☐	☐
➢Aspirin	☐	☐
➢Any Metals (e.g. Nickel, Mercury, etc.)	☐	☐
➢Latex Rubber	☐	☐
➢Other (please list)_____ _____		
10. Do you have a persistent cough or throat cleaning not associated with a known illness (lasting more than 3 weeks?)	☐	☐

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsion	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payer's and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____
Signature of patient (Parent/guardian if minor)

Medical History Update

X_____ Date_____
X_____ Date_____
X_____ Date_____

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