JournalSquareDental
YOUR SMILE IS OUR PRIORITY

DATE: _____

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Title: Mr. , Mrs. Ms. Miss. Dr. Other _____ I prefer to be called: _____

Birth Date (DD/MM/YYYY): _____ Sex: ☐ Male ☐ Female Social Security#: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: _____ City, State, Zip Code: _____

Home Phone: ( )_____ Work Phone: ( ) _____ Cell Phone: ( ) _____

EMAIL Address: _____ Occupation: _____

Employer: _____

If the patient is a dependent, please complete the following:

☐ YES ☐ NO Is patient covered by Dental Insurance?

☐ YES ☐ NO Is patient a dependent according to IRS standards?

☐ YES ☐ NO Is patient disabled?

☐ YES ☐ NO Does the patient attend college full-time? Name & Location of college: _____

METHOD OF PAYMENT

☐ CASH ☐ CHECK ☐ CREDIT / DEBIT

CONTACT IN CASE OF AN EMERGENCY

Closest relatives name(s) _____ Title: Mr. , Mrs. Ms. Miss. Dr. Other_____

Address (if different from patient) _____

Home Phone (if different from patient): _____ Cell Phone: _____

DENTIST

Patient's Dentist: _____ Address: _____

Last Date Seen: _____ Reason: _____

Next Appointment: _____

Name/Address of other dentist/dental specialist now being seen: _____

"We believe our purpose is to provide all of our patients with an exceptional level of dental health care, practiced within a warm, caring and supportive environment, and helping to inform how to make healthy lifestyle choices through education, commitment and great dentistry."

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GENERAL INFORMATION

What concerns you about your teeth? _____

Who may we thank for referring you? _____

Reason for your visit today? _____

Are you currently in pain ☐ YES ☐ NO if so, please describe: _____

Do you have dental problems now? ☐ YES ☐ NO Please describe:_____

_____

Do you love the way your smile looks? ☐ YES ☐ NO Please describe:_____

_____

How often do you floss? _____ What type of bristles do you use? ☐ Soft ☐ Hard ☐ Medium

Do you have bleeding gums? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No

PHYSICIAN

Patient's Physician _____ Address:_____

Last Seen _____ Reason _____

Next appointment _____ Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ Address _____

Reason: _____

Name _____ Address _____

Reason: _____

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INSURANCE INFORMATION – MUST BE COMPLETED IN FULL, please note that if you have any other dental insurance plans you must use both plans to coordinate benefits. The information provided will determine which carrier is the primary and which is the secondary.

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured:		
Address:		
Phone Number:		
Date of Birth (DD/MM/YYYY):		
Social Security Number ID No.:		
Employer Name & Employer Phone:		
Dental Insurance (Family, Individual)		
Group No. / ID No.:		
Medical Insurance Carrier:		

To the best of my knowledge, the information provided is accurate. In the event that there are any changes in my current insurance plans, I will provide that information to **Journal Square Dental**. I understand that failure to provide such information may cause delays in processing or payment of my claims and I agree to pay same if they are not paid timely as a result of such failure:

Signature: _____ Date: _____

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NOTIFICATION OF RESPONSIBILITY AND SIGNATURE AUTHORIZATIONS

I agree to make payments as services are rendered. I understand that if for any reason my dental insurance does not make expected payment or if my insurance is terminated, I will be responsible for the **TOTAL FEE**. I hereby authorize **Journal Square Dental** to execute in my name all payment application forms for treatment. The determination of treatment rendered by **Journal Square Dental** shall be conclusive.

Signature: _____ Date: _____

PATIENT HEALTH INFORMATION

Please list any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you may take.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Have you ever taken any medication to strengthen your bones? ☐ **Yes** ☐ **No** Please describe. _____

_____

Do you or have you ever had a substance abuse problem? ☐ **Yes** ☐ **No**

Do you chew or smoke tobacco? ☐ **Yes** ☐ **No**

Have you notice any changes in your face or jaws? ☐ **Yes** ☐ **No**

Are there any other physical problems?

_____

Women: Are your pregnant? ☐ **Yes** ☐ **No** Are you trying to become pregnant? ☐ **Yes** ☐ **No**

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain:

Bleeding disorders: _____ Diabetes _____

Arthritis _____ Severe Allergies _____

Unusual dental problems: _____

Other family medical conditions?

_____

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Your answers are for office records only, and are confidential. For the following questions, please mark yes, no or don't know / understand (dk/u):

MEDICAL HISTORY: Now or in the past, have you had any of the following:

Yes	No	Dk/U		Yes	No	Dk/U	
☐	☐	☐	Birth defects or hereditary problems	☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Bone fractures or major injuries?	☐	☐	☐	Skin disorder other than common acne)?
☐	☐	☐	Any injuries to face, head, neck?	☐	☐	☐	Do you eat a well balanced diet?
☐	☐	☐	Arthritis or joint problems?	☐	☐	☐	Asthma, sinus problems, hay fever?
☐	☐	☐	Endocrine or thyroid problems?	☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Diabetes or low sugar?	☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Kidney problems?	☐	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	☐	Cancer, tumor, radiation treatments or chemotherapy?	☐	☐	☐	Frequent Head aches or migraines?
☐	☐	☐	Stomach ulcer, hyperacidity, acid reflux?	☐	☐	☐	Do you frequently breathe through your mouth?
☐	☐	☐	Immune system problems?				**Have you had allergies or reactions to any of the following**
☐	☐	☐	History of osteoporosis?	☐	☐	☐	Local anesthetics (Novocaine, lidocaine, xylocaine)
☐	☐	☐	Gonorrhea, syphilis, herpes, sexually transmitted diseases?	☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	AIDS, HIV positive?	☐	☐	☐	Aspirin
☐	☐	☐	Hepatitis, jaundice, or other liver problems?	☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?	☐	☐	☐	Penicillin
☐	☐	☐	Seizures, fainting spells, neurologic problems?	☐	☐	☐	Other antibiotics
☐	☐	☐	Mental health disturbance or depression?	☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Vision, hearing, or speech problems?	☐	☐	☐	Acrylics
☐	☐	☐	History of eating disorder (anorexia, bulimia)?	☐	☐	☐	Plant pollens
☐	☐	☐	Hearth defects, heart murmur rheumatic heart disease	☐	☐	☐	Animals
☐	☐	☐	High or low blood pressure?	☐	☐	☐	Foods
				☐	☐	☐	Other substances: _____

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DENTAL HISTORY: Now or in the past, have you had any of the following:

Yes	No	Dk/U		Yes	No	Dk/U	
☐	☐	☐	Permanent or extra (supernumerary) teeth removed?	☐	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?	☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Chipped or injured primary or permanent teeth?	☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Any sensitive or sore teeth?	☐	☐	☐	Have you ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?	☐	☐	☐	Have you ever had an orthodontic consultation or treatment before now?
☐	☐	☐	Jaw fractures, cysts, infections?	☐	☐	☐	
☐	☐	☐	Any teeth treated with root canals or pulpotomies?	☐	☐	☐	
☐	☐	☐	"Gum boils," frequent canker sores or cold sores?				
☐	☐	☐	History of speech problems or speech therapy?				
☐	☐	☐	Difficulty breathing through nose?				
☐	☐	☐	Food impaction between the teeth?				
☐	☐	☐	Mouth breathing habit or snoring at night?				
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?				
☐	☐	☐	Teeth causing irritation to lip, cheek or gums?				
☐	☐	☐	Abnormal swallowing (tongue thrust)?				
☐	☐	☐	Tooth grinding or clenching?				
☐	☐	☐	Clicking, locking in jaw joints?				
☐	☐	☐	Soreness in jaw muscles or face muscles?				
☐	☐	☐	Ringing in ears, difficulty in chewing or opening jaw?				