Jackson Dental LLC
573-243-5200

Patient Information

Please take a moment to enter or update your information to help us provide you with the best possible dental care.

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor ☐ Separated/Divorced Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ Social Security #: _____

Place of Employment/School: _____

Spouse (or parents) name: _____

Spouse (or parents) employer: _____

Contact Information

Phone: (home) _____ (work) _____ (cell) _____

How would you prefer us to confirm appointments: ☐ text ☐ e-mail ☐ home phone ☐ cell phone

Email address: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone: _____

Has any member of your family been treated in our office? ☒ Yes ☐ No If so, who? _____

How did you find out about us? ☐ Yellow Pages ☐ sign ☐ internet ☐ mail ☐ newspaper

Who can we thank for sending you to our office _____

Insurance Information

Primary Dental Insurance: _____ Employer: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Information: Date of Birth: _____ Social Security #: _____

Secondary Dental Insurance: _____ Employer: _____

Who is responsible for your account? _____

Method of Payment

☐ Payment in full at each appointment

☐ Payment in full of my ***estimated*** portion after insurance benefit

☐ ***Care Credit*** patient financing plan (you will need to fill out a credit application)

Today's Date: _____

Please read and sign the information on the back of this form

Authorization

I hereby authorize payment from my insurance company directly to Jackson Dental. **I understand that I am responsible for all costs of dental treatment**. I also authorize Jackson Dental to administer medications and perform diagnostic and therapeutic procedures as necessary for proper dental care. The information provided here and on the medical history form is correct to the best of my knowledge.

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

☐ I have received a copy of this office's Notice of Privacy Practices.

Signature of patient, parent, or guardian (responsible party):

_____ Date: _____

[Relationship to Patient: _____]

Medical History

Patient Name: _____ Birth date: _____

Physician's Name: _____ Telephone: _____

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain on second page.
Have you had a serious illness or major surgery?	☐ Yes	☐ No	If yes, please explain on second page.
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please list medications on the second page.
Do you take, or have you taken, Phen-Fen or Redux, or other weight loss products?	☐ Yes	☐ No	
Are you currently taking blood thinners?	☐ Yes	☐ No	
Have you ever taken Fosamax, Boniva, Actonel, or other medications containing biophosphonates?	☐ Yes	☐ No	

Women, are you:

☐ Pregnant/trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Heart Attack/Failure	☐ Mitral Valve Prolapse
☐ Anemia	☐ Convulsions	☐ Heart Murmur	☐ Osteoporosis
☐ Angina	☐ Cortisone Medicine	☐ Heart Pacemaker	☐ Psychiatric Care
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Trouble/Disease	☐ Radiation Treatments
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Hemophilia	☐ Renal Dialysis
☐ Artificial Joint	☐ Emphysema	☐ Hepatitis A, B, C	☐ Rheumatic Fever
☐ Asthma	☐ Epilepsy or Seizures	☐ Herpes	☐ Sinus Trouble
☐ Blood Disease	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Excessive Thirst	☐ Hives or Rash	☐ Stroke
☐ Breathing Disorders	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Thyroid Disease
☐ Bruise Easily	☐ Frequent Cough	☐ Kidney Problems	☐ Tobacco Habit
☐ Cancer	☐ Frequent Headaches	☐ Leukemia	☐ Tuberculosis
☐ Chemotherapy	☐ Genital Herpes	☐ Liver Disease	☐ Ulcers
☐ Chest Pains	☐ Glaucoma	☐ Low Blood Pressure	☐ Venereal Disease
☐ Cold Sores/Fever Blisters	☐ Hay Fever	☐ Lung Disease	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

_____

Doctor's Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

List medications that you are taking including herbal supplements: _____

List any allergies (medications and environmental): _____

Other Comments: _____

Signature of Patient, Guardian, or Personal Representative:

Signature: _____ Date: _____

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. Do you experience dry mouth? ..... YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? ..... YES NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

Jackson Dental

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Please Print

Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)