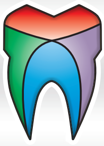

JEFFERSON DENTAL CLINICS™

PATIENT INFORMATION

Adult / Child Date: ______________

Last Name: ______________________________Male/Female

First Name: __________________MI: _____ Email: _________________________

Birth Date _____ /____/_____ Marital Status: Single / Married / Divorce/ Widower

Driver's license #:______________________________ # SS: ______________

Address: ______________________________________ Apt./Condo #: _________

City: ______________________________________ State ______ Zip: __________

Home phone: ____________________Cell phone: __________________________

Occupation: __________________Work phone: ____________________________

When and where are the times to contact you? ___________________________

Guarantor

if the patient is a minor, do you have a legal custody? Yes/No

☐ Spouse ☐ Parent or Tutor ☐ Legal Guardian ☐ Other: ______________

Last Name: ______________________________Male/Female

First Name: __________________MI: _____ Email: _________________________

Birth Date:_____ /_____/_____

Driver's license #: ______________________________ # SS: ______________

Address: ______________________________________ Apt./Condo #: _________

City: ______________________________________State: _____ ZIP: __________

Occupation: __________________Work phone: ____________________________

Occupation: __________________Work phone: ____________________________

When and where are the times to contact you? ___________________________

In case of an emergency, please provide the following information:

Name: __________________________________ Relationship: ______________

Work phone: ____________________________Home phone: _________________

How do you hear about us?

Which TV

☐ Univisión ☐ Telefutura ☐ Telemundo ☐ Azteca América ☐ Estrella TV

How do you hear about us?

____

Other:

____

OFFICE USE ONLY

I verbally reviewed the medical/ dental information above with the patient named herein.

Initials: ____________________________________ Date: ______________

Doctor's comments:__ ____

UPDATE:

Comment: ____

Signature: __________________________________ Date: ______________

Comment: ____

Signature: __________________________________ Date: ______________

PAYMENT OPTIONS

☐ Insurance ☐ Sonrisa Dental Plan

☐ Cash/Check ☐ Credit Card/Debit Card

DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? Yes/No

Have you ever had a problem with any previous dental work? Yes/No

Do your gums bleed? Yes/No

How many times a week do you brush?_______________ Floss? _________

MEDICAL HISTORY

Personal physician's name: ____

Phone: ______________________________________Date of last visit: ____________

Your current physical health is: Good / Regular / Poor

Are you currently under the care of a physician?: Yes/No

Please explain: ____

Are you taking any prescription/ over the counter drugs? Yes/No

Please list each one: ________________________________

____

Do you smoke or use tobacco in any way? Yes/No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS? (PLEASE CIRCLE)

Abnormal bleeding	Congenital heart defect	Hemophilia	Radiation treatment
AIDS, HIV+	Diabetes	Hepatitis	Rheumatic Scarlet fever
Alcohol or drug abuse	Difficulty breathing	Herpes, fever blisters	Seizure
Anemia	Emphysema	High Blood Pressure	Shingles
Arthritis	Epilepsy	Hospitalized	Sickle cells disease, traits
Artificial Bones	Fainting spells	Kidney problems	Sinus problems
Artificial Joints	Frequent headaches	Liver disease	Stroke
Artificial Valves	Glaucoma	Low blood pressure	Thyroid problems
Asthma	Hay fever	Lupus	Tuberculosis
Blood Transfusion	Heart attack	Mitral valve prolapse	Ulcers
Cancer, chemotherapy	Heart surgery	Pacemaker	Venereal Disease
Colitis	Heart murmur	Psychiatric problems	

Are you allergic to any of the following?

Aspirin	Codeine	Dental Anesthetics	Penicillin
Erythromycin	Latex	Jewelry	Tetracycline

List any patients medical condition(s): ______________________________

____

FOR WOMEN:

Are you taking birth control pills? Yes/No

Are you pregnant? Yes/No Week #: _________________Are you nursing? Yes/No

AGREEMENT

I acknowledge that this information is correct and will be held in the strictest confidence. I authorized Jefferson Dental Clinics to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for all dental cost, payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorized payment directly to Jefferson Dental Clinics of the group insurance benefits otherwise payable to me. I hereby authorized release of any information, including the diagnosis and record of treatment or examination rendered, to my insurance company.

Signature: __________________________________ Date: ______________