Patient Welcome Form

JEFFERSON™ DENTAL CLINICS

Patient Information

Adult/Child: _____ Date:_____

Last Name:_____ First Name:_____ MI:_____
Gender (Male/Female):_____ Email: _____ Birthdate:_____
Marital Status (Single/Married/Divorced/Widower): _____
Driver's License #: _____ S.S.# _____
Address: _____ Apt./Condo #: _____
City:_____ State: _____ Zip Code: _____
Home Phone: _____ Mobile Phone: _____
Occupation: _____ Work Phone: _____
When and where are the best times to contact you? _____

Guarantor

if the patient is a minor, do you have legal custody? _____

Relationship to Patient (Spouse/Parent/Tutor/Legal Guardian/Other): _____
Last Name:_____ First Name:_____ MI:_____
Gender (Male/Female):_____ Email: _____ Birthdate:_____
Marital Status (Single/Married/Divorced/Widower): _____
Driver's License #: _____ S.S.# _____
Address: _____ Apt./Condo #: _____
City:_____ State: _____ Zip Code: _____
Home Phone: _____ Mobile Phone: _____
Occupation: _____ Work Phone: _____
When and where are the best times to contact you? _____

Emergency Contact

in case of emergency please provide the following information:

Name: _____ Relationship:_____
Work Phone:_____ Home/Mobile Phone:_____

How did you hear about us?:

- ☐ Yellow Pages
- ☐ Family/Friend
- ☐ Event
- ☐ Radio
- ☐ TV
- ☐ Internet
- ☐ Flyer/Mail
- ☐ Outside Sign/Balloon
- ☐ Mobile Ad
- ☐ My Insurance Plan
- ☐ Yelp
- ☐ Facebook
- ☐ Other

Payment Options:

- ☐ Insurance
- ☐ Sonrisa Dental Plan
- ☐ Cash/ Check
- ☐ Credit/Debit Card
- ☐ I am interested in financing

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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?: _____

How many times a week do you floss?: _____

Medical History

Personal Physicians Name: _____ Phone Number:_____

Date of Last Visit: _____ Your current 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 tobacco in any way? (Yes/No): _____

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

Please select all that apply:

- ☐ Abnormal Bleeding
- ☐ AIDS, HIV+
- ☐ Alcohol or Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer, Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes, Fever Blisters
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valveprolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic; Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Are you allergic to any of the following?

Please select all that apply:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Latex
- ☐ Jewelry
- ☐ Tetracycline

For women:

Are you taking birth control pills?_____

Are you pregnant?:_____

Week #:_____

Are you nursing?: _____

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Agreement:

I acknowledge that this information is correct and will be held in the strictest confidence.
I authorize Jefferson Dental Clinics to contact me regarding promotions and services.
I authorize 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 paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment directly to Jefferson Dental Clinics of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company. Please type your full first and last name and date to represent your signature. You may also sign this form once you arrive to the office for your appointment.

Signature:_____ Date: _____

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: _____