Jon W. James DDS Inc.

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Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

How did you hear about us?

☐ Website ☐ Facebook ☐ Phone book ☐ Friend ☐ Family member

If friend or family, who may we thank?

_____

_____

Insurance information (If you have a secondary insurance please inform front staff):

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Medical and Dental History

Current Physician, Name, Address, Phone Number

_____

_____

Have you ever had a serious illness or operation? ◯ Yes ◯ No

If you answered "yes" to above, please briefly describe.

_____

_____

Do smoke or use tobacco? ◯ Yes ◯ No

Do you use alcohol, cocaine or other drugs? ◯ Yes ◯ No

Please list all current medications (If you have a list please give to front office staff)

_____

_____

_____

_____

Please check all that apply

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers

Dental History

Former Dentist/City/State

_____

_____

Please check all that apply:

- ☐ Bad Breath.....
- ☐ Grinding Teeth.....
- ☐ Pain Around Ear.....
- ☐ Sensitivity to Sweets.....
- ☐ Jaw Difficulty: Clicking or Pain....
- ☐ Bleeding Gums.....
- ☐ Lip or Cheek Biting.....
- ☐ Periodontal Treatment.....
- ☐ Sensitivity when Biting.....
- ☐ Tooth Pain.....
- ☐ Blisters on Lips or Mouth.....
- ☐ Loose Teeth or Broken Fillings....
- ☐ Sensitivity to Cold.....
- ☐ Frequent Headaches.....
- ☐ Finger Nail Biting.....
- ☐ Orthodontic Treatment.....
- ☐ Sensitivity to Heat.....
- ☐ Jaw, Head or Neck Injuries.....

I hereby authorize payment directly to Dr Jon W James DDS/Dr Aaron D Cardinal DDS for all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf.
I authorize the above doctors and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ **Date** _____

Response Date: ___/___/_____