JONES
DENTAL CARE

ADULT FORM

Welcome! We want you to know that we will do our very best to provide you with the most pleasant dental experience possible. To help us in this we need to have both the front and back sides of this form filled out with as much detail as possible. We pride ourselves in our accuracy and our attention to detail, and it makes our jobs easier if we can get all of your information charted properly. Thank you for your patience.
Sincerely, Dr. Ammon Jones and Dr. Aaron Jones

PATIENT INFO

_____ _____
NAME (FIRST, MI, LAST) P REFERRED NAME

MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ FULL-TIME STUDENT ☐ @_____

_____ _____ _____
BIRTH DATE (M / D / Y) SOCIAL SECURITY NUMBER EMAIL ADDRESS

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
HOME PHONE WORK PHONE CELL PHONE

_____ _____ _____ _____
ADDRESS (STREET/APT) CITY STATE ZIP CODE

SPOUSE INFO

_____ _____
NAME (FIRST, MI, LAST) PREFERRED NAME

_____ _____ _____
BIRTH DATE (M / D / Y) SOCIAL SECURITY NUMBER EMAIL ADDRESS

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
HOME PHONE WORK PHONE CELL PHONE

_____ _____ _____ _____
ADDRESS (IF DIFFERENT) CITY STATE ZIP CODE

HEALTH INFO

Please check any of the following that apply concerning your current health status:

[ ] AIDS/HIV+
[ ] ALLERGIES:
_____
_____
[ ] ARTIFICIAL JOINTS
[ ] ASTHMA
[ ] BLEEDING DISORDER
[ ] CODEINE ALLERGY
[ ] DIABETES
[ ] EPILEPSY
[ ] FAINTING/DIZZINESS
[ ] HEAD/JAW INJURY
[ ] HEART DISEASE
[ ] HEART MURMUR
[ ] HEPATITIS
[ ] HIGH BLOOD PRESSURE
[ ] MENTAL DISORDERS
[ ] PACEMAKER
[ ] PENICILLIN ALLERGY
[ ] PREGNANT NOW
DUE DATE _____
[ ] RHEUMATIC FEVER
[ ] SINUS PROBLEMS

If you are being treated by a physician who we may need to consult please explain and give his/her name and office number:

_____

Please detail any unusual complication or reaction you may have had to previous dental treatment:

_____

_____

Are you particularly anxious about dental work? If so, do you prefer that we offer you Nitrous Oxide (laughing gas) or other sedation?

_____

_____

Any preceding information that applies to me has been filled in correctly.
If I have any pertinent changes in my health history prior to future dental visits I will inform you.

X _____ _____
SIGNATURE DATE

CONTINUED

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DENTAL CARE

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EMPLOYMENT INFO

FOR PATIENT

EMPLOYER NAME _____ WORK PHONE _____

ADDRESS (STREET/APT) _____ CITY _____ STATE _____ ZIP CODE _____

FOR SPOUSE

EMPLOYER NAME _____ WORK PHONE _____

ADDRESS (STREET/APT) _____ CITY _____ STATE _____ ZIP CODE _____

INSURANCE INFO

PRIMARY INSURANCE: PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

NAME OF INSURED _____ INSURED'S BIRTH DATE (D / M / Y) _____

INSURED'S SSN OR SUBSCRIBER ID _____ GROUP NUMBER _____

INSURED'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

INSURED'S EMPLOYER _____ INSURANCE CO. PHONE NUMBER _____

INSURANCE CO. NAME AND ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SECONDARY INSURANCE: PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

NAME OF INSURED _____ INSURED'S BIRTH DATE (D / M / Y) _____

INSURED'S SSN OR SUBSCRIBER ID _____ GROUP NUMBER _____

INSURED'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

INSURED'S EMPLOYER _____ INSURANCE CO. PHONE NUMBER _____

INSURANCE CO. NAME AND ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

CONCENT TO EXAMINE

As a condition of treatment by this office I give consent to the doctors and staff of Jones Dental Care to examine and diagnoses my dental & orofacial structures & to provide treatment with my verbal approval.

X _____ _____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE RELATIONSHIP TO PATIENT