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. It makes our job easier if we can get all of your child's information charted properly. Thank you for your patience. Sincerely, Dr. ammon jones and Dr. aaron jones

PATIENT INFO

_____ _____
name (first, mi, last) preferred name

[ ] male [ ] female [ ] married [ ] single [ ] widowed [ ] full-time student @_____

Preferred Method of contact for appointment reminders (please check one):
[ ] cell phone [ ] home phone [ ] work [ ] email_____

_____
Address (street/apt) **city** **state** **zip code**

_____ _____
Birth date (M/D/Y) social security number

(_____)_____ (_____)_____ (_____)_____
cell phone Work phone Home (Land line) phone

SPOUSE INFO

_____ _____
name (first, mi, last) preferred name

_____
Address (if different) **city** **state** **zip code**

[ ] male [ ] female _____ _____
Birth dare (M/D/Y) Social Security Number

(_____)_____ (_____)_____ (_____)_____
cell phone Work phone Home (Land line) phone

PATIENT'S HEALTH INFO

[ ] aids/hiv +	[ ] diabetes	[ ] hepatitis	[ ] bleeding disorder
[ ] mental disorder	[ ] pregnant now	[ ] head/jaw injury	[ ] penicillin allergy
[ ] pacemaker	due date:_____	[ ] codeine allergy	[ ] heart disease
[ ] rheumatic fever	[ ] fainting/dizziness	[ ] artificial joints	[ ] high blood pressure
[ ] asthma	[ ] epilepsy	[ ] heart murmur	[ ] sinus problem

[ ] allergies: (please list)_____

Are your currently taking any medication(s)? If yes, please list:
_____

_____

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

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

_____

Are you particularly anxious about 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 of patient or legal guardian date relationship to patient

continued

ADULT FORM

EMPLOYMENT INFO

FOR PATIENT

Employer name _____ work phone _____

Address (street/apt) _____ city _____ state _____ zip _____

FOR SPOUSE

Employer name _____ work phone _____

Address (street/apt) _____ city _____ state _____ zip _____

DENTAL INSURANCE INFO

Primary insurance: patient's relationship to insured: [ ] self [ ] spouse [ ] child [ ] other

Name of insured _____ insured's birth date (m/d/y) _____

Ssn or subscriber id _____ group number _____

Insured's employer name _____ insurance phone number _____

Insurance co. name and address _____ city _____ state _____ zip code _____

Insured's address (if different than patient's) _____ city _____ state _____ zip code _____

secondary insurance: patient's relationship to insured: [ ] self [ ] spouse [ ] child [ ] other

Name of insured _____ insured's birth date (m/d/y) _____

Ssn or subscriber id _____ group number _____

Insured's employer name _____ insurance phone number _____

Insurance co. name and address _____ city _____ state _____ zip code _____

Insured's address (if different than patient's) _____ city _____ state _____ zip code _____

CONSENT TO EXAMINE & PROVIDE TREATMENT

As a condition of treatment by this office I give consent to the doctors and staff of jones dental care to examine and diagnose my dental & orofacial structures & to provide treatment with my verbal approval.

X _____

Signature of patient or legal guardian date relationship to patient

REFERRAL INFO

We love to reward those who refer others to our practice. Send in a friend and we'll send you a gift!

Who may we thank for referring you to our practice?

X _____