301 American Ave
Jefferson, IA 50129
(515)386-3768

PATIENT INFORMATION

Welcome to Jefferson Family Dentistry, we're glad you're here! Please fill out this form as completely as you can. If you have any questions, we'd be happy to help you.

PERSONAL

Name____
Last First MI (Preferred/Nickname)

Birthdate________________ SS#_____________________ Gender: [ ] M [ ] F Married: [ ]Y [ ]N

Home Phone__________________ Work Phone____________________ Cell Phone__________________

Email____

Preferred contact method? [ ]Home [ ]Work [ ]Cell

Preferred contact method for confirmations? [ ]Home [ ]Work [ ]Cell

Student status if dependent over 19? *(for insurance)* [ ]Nonstudent [ ]Fulltime [ ]Part-time

How did you hear about us? Family[ ] Friend[ ] Sign[ ] Advertisement[ ] Insurance Plan[ ] Other[ ]

____

(*If someone referred you here, please write down their name so we can thank them.)*

ADDRESS

Check box if same for entire family [ ]

Address____

Address 2____

City______________________________ State________Zip_____________________

INSURANCE POLICY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____________________Birth date:_______________Subscriber ID # ______________________

Insurance Company ____Phone______________________________

Employer____________________________Group Name_______________________Group #__________________

Please present insurance card to receptionist.

INSURANCE POLICY 2 (if applicable)

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____________________Birth date:_______________Subscriber ID #______________________

Insurance Company ____Phone______________________________

Employer____________________________Group Name_______________________Group #__________________

EMERGENCY CONTACT

Name of friend or relative (*not living at same address*)____

Relationship to patient?_______________Home Phone #___________________Cell Phone #_________________

To the best of my knowledge, all information given is accurate.

Patient/Guardian Signature____**Date:**_____________________

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that payment is due at the time of service, and if I begin major treatment that involves lab work, I will be responsible for the fee at that time. Other payment arrangements may be available and it is my responsibility to understand my payment obligations.
* I understand that the financial information given is **Only an Estimate**. Every effort will be made to help me with my insurance, but my insurance company has the final say. I will be responsible for services not covered by my insurance.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* If sent to collections, I agree to pay all related fees and court costs.
* I understand that treatment plans may change mid-treatment, and I will be responsible for the work actually completed.

Signature____ Date______________________

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices, and understand that I may request a copy at any time. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature____ Date______________________

MEDICAL HISTORY

Name/Location of Physician:____ Phone______________________

Have you ever had a serious illness, operation, or been hospitalized? *(If so, please explain)*__________________

____

Medications Currently Taking *(please list):*

[ ]None ____________________________________

____

____

Allergies:

[ ]None [ ]Medication [ ]Food [ ]Latex [ ]Other (*list*):

____

____

Current Medical Conditions*(circle all that apply/explain below):* asthma, bleeding problems, cancer, diabetes, depression, fibromyalgia, heart disease, high blood pressure, joint replacement, kidney disease, liver disease, psychiatric treatment, sinus issues, stroke, ulcers, rheumatic fever

[ ]None [ ]Other *(please list):* ____

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Tobacco use? _________________________________Controlled Substances? ___________________________

(*Women*) Are you pregnant or do you think you may be pregnant? [ ]Yes [ ]No

Have you ever taken antibiotics before dental treatment? [ ]Yes [ ]No *Explain*:_____________________________

Is there anything not listed above we should know about your health?______________________________________

DENTAL HISTORY

Reason for today's visit: *(circle)* Exam/Cleaning Pain/Swelling Broken Tooth/Filling

For how long?____________ Describe Problem:____

Date of last dental visit? ___/___/___ Date of last dental cleaning? ___/___/___ Date of last xrays? ___/___/___

Do your gums bleed? [ ]Yes [ ]No Have you been told you have gum disease? [ ]Yes [ ]No

Are your teeth sensitive to? [ ]Sweets [ ]Cold [ ]Heat [ ]Pressure Do you have jaw pain? [ ]Yes [ ]No

Do you have chronic dry mouth? [ ]Yes [ ]No Are you happy with your smile? [ ]Yes [ ]No

What would you change about your mouth/teeth if you could?____

Is there anything not listed above we should know about your dental history?_________________________________

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