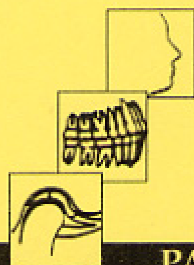

Interdisciplinary Dentofacial Diagnostic Systems

BRAD JONES, D.D.S.

GENERAL DENTISTRY

Chart Number: __________

Date: __________

PATIENT'S INFORMATION (please completely fill out first and second pages)

Patient's Full Name: ______________________ Name you like to be called by: __________
First, Middle, Last

Patient's Address: ______________________ Soc. Sec. #: __________
Street, Apt. No. City, State, Zip

Home Phone: (____) __________ Date of Birth: ___/___/___ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Place of Employment or School and Grade: ______________________ Phone: (____)__________

Person to contact in case of emergency: ______________ Relationship: __________ Phone: (____)__________

Contact's Address: ______________________

Whom May We Thank for Referring You? ______________ Name and Ages of Children or Siblings: __________

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: ______________________ Relation to Patient: __________
First, Middle, Last

Full Home Address: ______________________ Home Phone (____) __________
Street, Apt. No. City, State, Zip

If Less than 3 Years at above, Previous Address: ______________________ Date of Birth ___/___/___

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Occupation: __________

Driver's License No.: __________ Social Security No.: __________ Employer: __________

Work Phone (____) __________ Years at Employer: _____ Employer's Address: __________

Name of ☐ Spouse ☐ Other Parent ______________________ Full Address: __________
or ☐ Secondary Responsible Person: *First, Middle, Last*

Date of Birth: __________ Social Security No.: __________ Home Phone (____)__________ Work Phone (____) __________

Employer: ______________________ Occupation (type of business): __________ Years at Employer: _____

INSURANCE INFORMATION

If you have insurance, this section must be completed

Dental Insurance Company (name and address): ______________________

Name of Subscriber / Policy Holder: ______________________ Relationship to Patient: __________

Group #: __________ Identification #: __________ Other Number(s) __________

Secondary Dental Insurance Company (name and address): ______________________

Name of Subscriber / Policy Holder: ______________________ Relationship to Patient: __________

Group #: __________ Identification #: __________ Other Number(s) __________

Medical Insurance Company (name and address): ______________________

Name of Subscriber / Policy Holder: ______________________ Relationship to Patient: __________

Group #: __________ Identification #: __________ Other Number(s) __________

Secondary Medical Insurance Company (name and address): ______________________

Name of Subscriber / Policy Holder: ______________________ Relationship to Patient: __________

Group #: __________ Identification #: __________ Other Number(s) __________

RELEASE

I authorize the doctor or other dentists or health care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.

I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.

I consent to the release of credit reports and information regarding my credit history to the doctor(s).

I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Date: __________ Patient or Guardian's Signature ______________________

MEDICAL AND DENTAL HISTORY (to be completed by patient)

Patient's Full Name: ____________________ ☐ Male ☐ Female
Date of Birth: __________ Age: (years)______ (months)______ Weight:______ Height:______
Patient's ☐ Current ☐ Previous Dentist(s): ____________________ Date of Last Dental Cleaning:______
Patient's ☐ Current ☐ Previous Physician(s): ____________________ Date of Last Physical Exam:______

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions (use bottom of page if necessary). THANK YOU.

A. Please list your chief concerns for treatment: (# in order of priority): ____________________
B. What or who motivated you to seek treatment and what do you expect? ____________________
C. Describe anything that bothers you about the appearance of your teeth, smile or face: ____________________
D. Describe any injuries or blows to your face, jaw, mouth or teeth: ____________________
E. List all current medications including non-prescriptions: ____________________
F. List all drug allergies: ____________________
G. List all previous surgeries or hospitalizations: ____________________

Please ✓ if "yes" to every question appropriate, and thoroughly describe (use space at bottom of page if necessary)

MEDICAL

1. High Blood Pressure ______ ☐
2. Chest pains or heart attack ______ ☐
3. Stroke ______ ☐
4. Rheumatic Fever ______ ☐
5. Shortness of breath or swollen ankles ______ ☐
6. Any heart trouble, murmur, or mitral valve prolapse ______ ☐
7. Prosthetic devices (heart, valve, hip, etc.) ______ ☐
8. Any lung disease (T.B., emphysema, etc.) ______ ☐
9. Asthma ______ ☐
10. Allergies or hay fever ______ ☐
11. Sinus problems ______ ☐
12. Mouthbreathing or excessive snoring ______ ☐
13. Ulcers or stomach problems ______ ☐
14. Diabetes ______ ☐
15. Hepatitis or liver disease ______ ☐
16. Kidney or bladder disease ______ ☐
17. Thyroid trouble ______ ☐
18. Connective tissue disease ______ ☐
19. Sexually transmitted disease ______ ☐
20. Arthritis or rheumatism ______ ☐
21. Cancer (type, date) ______ ☐
22. Serious illnesses not listed (list type, date) ______ ☐
23. Subject to prolonged bleeding or bruise easily ______ ☐
24. A contact lens user ______ ☐
25. Glaucoma ______ ☐
26. Epilepsy, convulsions or seizures ______ ☐
27. Psychiatric therapy or emotional problems ______ ☐
28. Do you have HIV (AIDS)? ______ ☐
29. Have you been exposed to HIV? ______ ☐
30. Have you been tested for HIV? ______ ☐
31. Pregnant or possible pregnant ______ ☐
32. Taking birth control pills ______ ☐
33. Drink coffee (cups per day) ______ ☐
34. Use tobacco (types/how much) ______ ☐
35. Consume alcoholic beverages ______ ☐
36. Pain, popping, catching or locking in jaw joints ______ ☐
37. Clench or grind your teeth ______ ☐
38. Wake up with sore jaws ______ ☐
39. Frequent headaches (How many per week?___) ______ ☐
40. Dizziness, ringing or pain in ears ______ ☐
41. Tenderness or stiffness in the jaw, neck or back ______ ☐
42. History of TMJ (jaw joint) problems or therapy ______ ☐

DENTAL

50. Treated for or told you have gum disease ______ ☐
51. Treated or consulted for orthodontic therapy ______ ☐
52. Had any oral surgery ______ ☐
53. Dental x-rays taken in the last year ______ ☐
54. Excessive fear of dental treatment ______ ☐
55. Brush your teeth (how often) ______ ☐
56. Floss your teeth (how often) ______ ☐
57. Bad breath or unpleasant tastes in your mouth ______ ☐
58. Bleeding gums ______ ☐
59. Sore teeth ______ ☐
60. Tooth sensitivity (hot, cold, sweets) ______ ☐
61. Fever blisters or mouth ulcers ______ ☐
62. Suck your thumb, finger or lip (now or in the past?) ______ ☐
63. Tongue thrusting habit ______ ☐
64. Gag easily ______ ☐
65. Place a high priority on keeping your natural teeth ______ ☐

Please expand on the above information (refer to letter or number) or add anything you feel is important: ____________________

The above information is accurate and complete to the best of my knowledge:

Date:______ **Patient or Guardian's Signature:**____________________ **Doctor's Signature:**____________________

Updated:______ P or G's Initials:______ Doctor's Initials:______; ______, ______, ______; ______, ______, ______;