DeJesus Dental Group

Age_____Date_____

Patients Name_____Date of Birth_____ □ Male □ Female
Last *First* *Initial*

If Child: Parent's Name_____

How do you wish to be addressed?
□ Single □ Married □ Separated □ Divorced □ Widowed □ Minor

Residence – Street_____

City_____ State_____ Zip_____

Business Address_____

Telephone: Res._____ Bus._____

Fax _____ Cell Phone #_____

Email_____

Patient/Parent Employed By_____

Present Position_____

How Long Held_____

Spouse/Parent Name_____

Spouse Employed By_____

Present Position_____

How Long Held_____

Who is Responsible for this account_____

Drivers License No._____

Method of Payment □ Insurance □ Cash □ Credit Card

Purpose of Call_____

Other Family Members in this Practice_____

_____

Whom may we thank for this referral_____

Patient/Parent Social Security No._____

Spouse/Parent Social Security No._____

Someone to notify in case of an emergency not living with you_____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name_____ Date of Birth_____

Relationship to Patient_____

Employer Name_____

Name of Insurance Co._____

Address_____

Telephone_____

Program or Policy #_____

Social Security No._____

Union Local or Group_____

DENTAL INSURANCE 2ND COVERAGE

Employee Name_____ Date of Birth_____

Relationship to Patient_____

Employer Name_____

Name of Insurance Co._____

Address_____

Telephone_____

Program or Policy #_____

Social Security No._____

Union Local or Group_____

CONSENT:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.
My consent to disclosure of records shall be effective until I revoke in writing.
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.
PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE_____

REGISTRATION

DeJesus Dental Group

Patients Name_____Date of Birth_____

1. Purpose of initial visit?_____
2. Are you aware of a problem?_____
3. How long since your last visit?_____
4. What was done at that time?_____
5. Previous dentist's name_____
   Address_____Tel._____
6. When was the last time your teeth were cleaned?_____
   PLEASE CIRCLE THE APPROPRIATE ANSWER
7. Have you made regular visits?.....YES....NO
   How often?_____
8. Were dental x-rays taken?.....YES....NO
9. Have you lost any teeth or have any teeth been removed?.....YES....NO
   Why?_____
10. Have they been replaced?.....YES….NO
11. How have they been replaced?
    a. Fixed Bride_____Age_____
    b. Removable Bridge_____Age_____
    c. Denture_____Age_____
    d. Implant_____Age_____
12. Are you unhappy with the replacement……..YES….NO
    Why?_____
13. Would you like to know about permanent replacements?.....YES….NO
14. Have you ever had any problems with previous dental treatment?.....YES….NO
15. Do you clench or grind your teeth?.....YES….NO
16. Does your jaw click or pop?.....YES….NO
17. Have you experienced pain/soreness in your face or around your ear?.....YES…NO
18. Do you have frequent headaches, neck aches or shoulder aches?.....YES….NO
19. Does food get caught in your teeth?.....YES….NO
20. Are your teeth sensitive to: (circle all that apply) Hot Cold Sweets Pressure
21. Do your gums bleed or hurt?.....YES….NO
22. Do you experience dry mouth?.....YES….NO
23. How often do you brush your teeth?_____When_____
24. Do you use dental floss?.....YES….NO
25. Are any of your teeth loose, tipped, shifted or chipped?.....YES….NO
26. Are you unhappy with the appearance of your teeth?.....YES….NO
27. How do you feel about your teeth in general?.....YES….NO
28. Do you feel your breath is offensive at times?.....YES….NO
29. Have you ever had gum treatment or surgery?.....YES….NO
30. Have you ever had orthodontic work?.....YES….NO
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
32. Do you have any questions or concerns?.....YES….NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTISTS SIGNATURE_____DATE_____

COMMENTS

DENTAL HISTORY

DeJesus Dental Group

Patients Name_____Date of Birth_____

PLEASE CIRCLE THE APPROPRIATE ANSWER

1. Physician's Name_____
   Adreess_____
   Phone_____
2. Are you under a physician's care?.....YES….NO
   Since when?_____Why?_____
3. When was your last complete physical exam?_____
4. Are you taking any medication or substances?.....YES….NO

(If yes, please list medications in the comments section or on the back of this form)

5. Do you take health related substances? (Vitamins, herbal supplements, etc) YES….NO
6. Are you allergic to any medications or substances? (please list)……YES….NO
7. Do you have any other allergies or hives? ……..YES....NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....YES....NO
9. Are you sensitive to any metals or latex?.....YES....NO
10. Are you pregnant or suspect to be?.....YES….NO
11. Do you use any birth control medications?.....YES….NO
12. Have you ever been treated or been told you might have heart disease…….YES….NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?.....YES….NO
14. Have you ever had rheumatic fever?.....YES….NO
15. Are you aware of any heart murmurs?.....YES….NO
16. Do you have high or low blood pressure? (please circle)……...YES….NO
17. Have you ever had a serious illness or major surgery?.....YES…NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?.....YES….NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment for bone tumors, excessive calcium in your blood or osteoporsis?YES….NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES….NO
21. Do you have any artificial joints/prosthesis?.....YES….NO
22. Do you have any blood disorders, such as anemia, leukemia, etc?.....YES….NO
23. Have you ever bled excessively after being cut or injured?.....YES….NO
24. Do you have any stomach problems?.....YES….NO
25. Do you have any kidney problems?.....YES….NO
26. Do you have any liver problems?.....YES….NO
27. Are you diabetic?.....YES….NO
28. Do you have fainting or dizzy spells?.....YES….NO
29. Do you have asthma?.....YES….NO
30. Do you have epilepsy or seizure disorders?.....YES….NO
31. Do you or have you had venereal or any sexually transmitted disease?.....YES….NO
32. Have you tested HIV positive?.....YES….NO
33. Do you have AIDS?.....YES….NO
34. Have you had or do you test positive for hepatitis?.....YES….NO
35. Do you or have you had T.B.?.....YES….NO
36. Do you smoke, chew, use snuff or any other forms of tobacco?.....YES….NO
37. Do you regularly consume more than one or two alcoholic beverages a day?YES....NO
38. Do you habitually use controlled substances?.....YES….NO
39. Have you had psychiatric treatment?.....YES….NO
40. Have you taken any prescription drugs fenfluramine, fenfluramin combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? …….YES….NO
41. Do you have any disease condition, or problem not listed? If so, explain_____
42. Is there anything else we should know about your health that we have not covered in this form?_____
43. Would you like to speak to the Doctor privately about the problem?.....YES….NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTISTS SIGNATURE_____DATE_____

MEDICAL HISTORY

SECTION A: **The Patient.**

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Patient Number:_____ Social Security Number:_____

SECTION B: **Acknowledgement of Receipt of Privacy Practices Notice.**

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:_____ Date:_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name:_____

Relationship to Individual:_____

SECTION C: **Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

_____

SIGNATURE

I attest that the above information is correct.

Print Name:_____ Date:_____

Signature:_____ Title:_____

Include this acknowledgement of receipt in the Individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE