JACOBSON DENTAL
DENTAL REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____

SS/HIC/Patient ID# _____

Patient Name(Last)_____

(First)_____(MI)_____

Address _____

City _____

State _____ Zip _____

Email _____

Sex __ Male __ Female Age _____

Birthdate _____

___ Married ___Widowed ___Single ___Minor

___ Separated ___Divorced ___Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

2. DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance _____

Group # _____

Is patient covered by additional insurance? ___ yes ___ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign Directly to Dr. Jacobson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my Signature on all insurance submissions. The above-named dentist may use my healthcare information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below

_____

Signature of patient, parent, guardian or personal representative

_____

Print Name of patient, parent, guardian or personal representative

_____ _____

Date Relationship to Patient

Whom may we thank for referring you? _____

3. PHONE NUMBERS

Phone (____) _____ Work (____) _____ Ext _____ Cell (____)_____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Place (____) _____

4. DENTAL HISTORY

Reason for today's visit _____ _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

Bad Breath	___ Yes ___ No	Lip or cheek biting	___Yes ___ No
Bleeding Gums	___ Yes ___ No	Loose teeth or broken fillings	___ Yes ___ No
Blisters on lips or mouth	___ Yes ___ No	Mouth breathing	___ Yes ___ No
Burning sensation on tongue	___Yes ___ No	Orthodontic treatment	___ Yes ___ No
Chew on one side of mouth	___ Yes ___ No	Pain around ear	___ Yes ___ No
Cigarette, pipe, or cigar smoking	___ Yes ___ No	Periodontal treatment	___ Yes ___ No
Clicking or popping jaw	___ Yes ___ No	Sensitivity to cold	___ Yes ___ No
Dry mouth	___ Yes ___ No	Sensitivity to heat	___ Yes ___ No
Fingernail biting	___ Yes ___ No	Sensitivity to sweets	___ Yes ___ No
Food collection between the teeth	___ Yes ___ No	Sensitivity when biting	___ Yes ___ No
Foreign Objects	___ Yes ___ No	Sores or growths in your mouth	___ Yes ___ No
Grinding Teeth	___ Yes ___ No		
Gums swollen or tender	___ Yes ___ No	How often do you floss? _____	
Jaw pain or tiredness	___ Yes ___ No	How often do you brush ? _____	

5. HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ____ Yes ____ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ____ Yes ____ No

AIDS/HIV	___ Yes ___ No	Diabetes	___ Yes ___ No	Radiation Treatment	___ Yes ___ No
Anemia	___ Yes ___ No	Emphysema	___ Yes ___ No	Respiratory Disease	___ Yes ___ No
Arthritis, Rheumatism	___ Yes ___ No	Epilepsy	___ Yes ___ No	Scarlet Fever	___ Yes ___ No
Artificial Heart Valves	___ Yes ___ No	Fainting or Dizziness	___ Yes ___ No	Shortness of Breath	___ Yes ___ No
Artificial Joints	___ Yes ___ No	Glaucoma	___ Yes ___ No	Sinus Trouble	___ Yes ___ No
Asthma	___ Yes ___ No	Headaches	___ Yes ___ No	Skin Rash	___ Yes ___ No
Back Problems	___ Yes ___ No	Heart Murmur	___ Yes ___ No	Special Diet	___ Yes ___ No
Bleeding abnormally		Heart Problems	___ Yes ___ No	Stroke	___ Yes ___ No
with extractions		Hepatitis Type ____	___ Yes ___ No	Swollen Feet or Ankles	___ Yes ___ No
or surgery	___ Yes ___ No	Herpes	___ Yes ___ No	Swollen Neck Glands	___ Yes ___ No
Blood Disease	___ Yes ___ No	High Blood Pressure	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Cancer	___ Yes ___ No	Jaundice	___ Yes ___ No	Tonsillitis	___ Yes ___ No
Chemical Dependency	___ Yes ___ No	Jaw Pain	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Chemotherapy	___ Yes ___ No	Kidney Disease	___ Yes ___ No	Tumor or Growth on Head	
Circulator Problems	___ Yes ___ No	Liver Disease	___ Yes ___ No	or Neck	___ Yes ___ No
Congenital Heart		Low Blood Pressure	___ Yes ___ No	Ulcer	___ Yes ___ No
Lesions	___ Yes ___ No	Mitral Valve Prolapse	___ Yes ___ No	Venereal Disease	___ Yes ___ No
Cortisone Treatments	___ Yes ___ No	Nervous Problems	___ Yes ___ No	Weight Loss, unexplained	___ Yes ___ No
Cough, Persistent or		Pacemaker	___ Yes ___ No		
Bloody	___ Yes ___ No	Psychiatric Care	___ Yes ___ No		

Do you wear contact lenses? ___ Yes ___ No

Are You Pregnant? ___ Yes ___ No Due Date _____ Are you nursing? ___ Yes ___ No

Taking birth control pills? ___ Yes ___ No

6. Medications

List any medications you are currently taking

_____

_____

_____

Allergies

___ Aspirin

___ Barbiturates (Sleeping pills)

___ Codeine

___ Iodine

___ Local Anesthetic

___ Penicillin

___ Sulfa

___ Other_____

____ ___ Latex ____________________________