PATIENT REGISTRATION

Date_____

Patient's Name _____ Nickname _____

Date of Birth ____/_____/_____ Email Address _____

Address _____

City, State, Zip _____

Home/Cell Phone _____ Business Phone _____

SS# _____ Male ____ Female ____ Single ____ Married ____ Divorced ____

Employer _____ Occupation _____

Emergency Contact _____ Phone Number _____

Who is responsible for this account? _____ Relationship _____

Address (If different from aboe) _____

DENTAL INSURANCE INFORMATION

ID#_____ Group # _____ Phone _____

Employee _____ DOB _____ SS#_____

Insurance Company _____

Insurance Address _____

Effective Date _____

Secondary Dental Insurance

ID#_____ Group # _____ Phone _____

Employee _____ DOB _____ ____ SS#_____

Insurance Company _____

Insurance Address _____

Effective Date _____

Signature _____ Date _____

New Patient Oral Health Questionnaire

1. How did you hear about us?

2. Are you ever nervous during dental visits? Yes ☐ No ☐

3. Are you interested in changing your teeth? Yes ☐ No ☐

4. If so, what would you like to change?

Whiter Teeth	☐	Straighter Teeth	
Replace Missing Teeth	☐	Gaps or Spaces	
Misshapen Teeth	☐	Healthy Teeth	

5. When was your last dental cleaning and exam? _____

6. Do your gums bleed when you brush or floss? _____

7. Do you snore, ever wake from sleep gasping for breath, or has your bed partner ever told you that you stop breathing when sleeping? Yes ☐ No ☐

8. When discussing your oral health, how would you like your information;

Big Picture ☐ Some Details ☐ I Want to Know Everything ☐

MEDICAL HISTORY

Jacksonville Dental Excellence

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins, or herbal supplements? ☐ Yes ☐ No Please list below:

_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date _____

Do you use tobacco in any form? ☐ Yes ☐ No If yes, what form and how much? _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? ☐ Yes ☐ No

Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, please check boxes below.

☐ Penicillin
☐ Latex or Rubber ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes		Yes		Yes	
☐	Heart Trouble/Disease	☐	Lung or Breathing Problems	☐	Severe Headaches
☐	Heart Murmur	☐	Shortness of Breath	☐	Fainting or Dizzy Spells
☐	Irregular Heartbeat	☐	Sinus Trouble	☐	Epilepsy, Seizures or Convulsions
☐	Angina or Chest Pain	☐	Asthma	☐	Psychiatric Care
☐	Heart Attack or Failure	☐	Chronic Cough	☐	Hepatitis, Jaundice or Liver disease
☐	Congenital Heart Disorder	☐	Emphysema	☐	Arthritis, Gout or Rheumatism
☐	Mitral Valve Prolapse	☐	Tuberculosis (TB)	☐	Artificial Joint
☐	Rheumatic Fever	☐	Pain in jaw joints	☐	Excessive Thirst
☐	Artificial Heart Valve	☐	Tumor or Cancer	☐	Hypoglycemia
☐	Heart Pacemaker	☐	Long-term Cortisone Treatment	☐	Thyroid Disease
☐	Heart Surgery	☐	Chemotherapy or Radiation	☐	Blood Transfusion
☐	Stroke	☐	Neck or Back Pain	☐	Bleeding Disorder
☐	Aneurysm	☐	Depression with Antidepressants	☐	Major Surgery
☐	High Blood Pressure	☐	Bruise Easily	☐	Diabetes
☐	Low Blood Pressure	☐	HIV Positive or AIDS		

Have you ever had any other disease, problem or condition not listed above? ☐ Yes ☐ No Discuss _____

_____

Do you wish to speak privately to the dentist about any problems? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____

COVID SCREENING FORM

Patient Name: _____

Have you had the COVID Vaccine? Yes ☐ No ☐

In the past, have you contracted COVID-19 and have fully recovered? Yes ☐ No ☐

If not, are you currently displaying any symptoms consistent with COVID-19? If so, please let us know. Yes ☐ No ☐

Have you recently come into contact with anyone who has tested positive for COVID-19? If so, please let us know. Yes ☐ No ☐