Janus Dentistry

ABOUT YOU

Today's Date: _____ Would you like an e-mail reminder? Yes No E-mail
Address:_____

Name:_____ I prefer to be called: _____ Male Female
Last First Mi Mr. Mrs. Ms Dr

Birthday___/___/___ Age:____ SSN#:_____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Mobile #: (____)_____ Work #:(____)_____ DL#:_____

Where & when are best times to reach you?_____ How did you hear about us?_____ _____

Employer: How long there? Occupation:

Person Responsible for Account if other than yourself (Parent/Legal Guardian)

Name: _____ Relation:_____ Home Phone #:(___)_____ SSN#:_____
Employer:_____ Work #:(____)_____ Ext:_____ DOB:_____
Billing Address:_____
Street City State Zip

SPOUSE INFORMATION

His/her Name:_____ Birthdate:___/___/___ SSN#:_____
Employer:_____ Work #: (____)_____ Ext:_____ DL#:_____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? Yes No Dental Coverage? Yes No
Insurance Co. Name:_____ Phone #:(____)_____ Group#:_____
Insured's Name:_____ SSN#:_____ DOB:___/___/___ Relation:_____
Insured's Employer:_____ Employer's Address:_____
Street City State Zip

DENTAL HISTORY

Why have you come to the dentist today?_____
_____

Are you currently in pain?	Yes	No	Have you ever had periodontal disease?	Yes	No
Do you require antibiotics before dental treatment?	Yes	No	Do you have mobility on your teeth?	Yes	No
Have you experienced problems associated with any previous dental work?	Yes	No	Are your teeth sensitive to hot, cold, or anything else? _____		
Do you know or have you ever experienced pain or discomfort in your jaw joint? (TMJ/TMD)	Yes	No	Do you still have wisdom teeth?	Yes	No
Your current health is	Good Fair	Poor	Do you have any loose fillings?	Yes	No
Do you floss daily?	Yes	No	Would you like fresher breath?	Yes	No
Do your gums ever bleed or itch?	Yes	No	Would you like whiter teeth?	Yes	No
			Previous Dentist: _____		
			Last Visit:_____		
			Are you happy with the way your smile looks?	Yes	No
			If not, what would you change?_____		

Continue on back

MEDICAL HISTORY

Do you have a personal physician? Yes No
Physician's Name:_____
Phone #:(____)_____ Date last visit___/___/___
Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes No
Please explain:_____
Do you smoke or use tobacco in any other form? Yes No

For Women: Are you taking birth control pills? Yes No
Are you pregnant? Yes No Not Sure
Week#_____ Are you nursing? Yes No

Are you allergic to any of the following?

Y N	Aspirin	Y N	Jewelry/Metals
Y N	Barbiturates	Y N	Latex
Y N	Codeine	Y N	Penicillin
Y N	Dental Anesthetics	Y N	Sedatives
Y N	Erythromycin	Y N	Sulfa Drugs

Please list additional drugs/materials that cause allergic reactions:
_____
_____

Are you taking any of the following?

Y N	Acetaminophen	Y N	Blood Thinners	Y N	Insulin/Diabetes	Y N	Thyroid Meds
Y N	Antibiotics	Y N	Blood Pressure Meds	Y N	Nitroglycerin	Y N	Tranquilizers
Y N	Antihistamines	Y N	Cold Remedies	Y N	Recreational Drugs		
Y N	Aspirin	Y N	Digitals/Heart Meds	Y N	Steroids/Cortisone		

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes No If yes, Please list each one:_____

Do you or have you experienced the following?

Y N	Abnormal Bleeding	Y N	Difficulty Breathing	Y N	Headaches	Y N	Psychiatric Problems
Y N	Alcohol Abuse	Y N	Drug Abuse	Y N	Herpes	Y N	Radiation
Y N	Anemia	Y N	Emphysema	Y N	Hepatitis ____	Y N	Seizures
Y N	Arthritis	Y N	Epilepsy	Y N	High Blood Pressure	Y N	Shingles
Y N	Artificial Bones/Joints	Y N	Fainting Spells	Y N	HIV/AIDS	Y N	Sickle Cell Disease
Y N	Asthma	Y N	Fever Blisters	Y N	Kidney Problems	Y N	Sinus Problems
Y N	Blood Transfusion	Y N	Glaucoma	Y N	Liver Disease	Y N	Steroid Problem
Y N	Cancer	Y N	Hay Fever	Y N	Low Blood Pressure	Y N	Stroke
Y N	Chemotherapy	Y N	Heart Attack	Y N	Lupus	Y N	Thyroid Problems
Y N	Chicken Pox	Y N	Heart Murmur	Y N	Mitral Valve Prolapsed	Y N	Tonsillitis
Y N	Colitis	Y N	Heart Surgery	Y N	Pacemaker	Y N	Tuberculosis(TB)
Y N	Congenial Heart Defect	Y N	Hemophilia	Y N	Persistent Cough	Y N	Venereal Disease

Please List any serious medical condition(s) that you have experienced:_____
_____

AUTHORIZATIONS

I affirm that the information I have is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT THE TIME OF SERVICE

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ insurance Co. and I assign Directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date