WELCOME

Jason M. Atack, DMD

About You:

Today's Date:_____

Patient Name:_____ Preferred Name: _____
LAST FIRST MI

❒ Male ❒ Female Birthdate:_____ Age:_____

Home Address:_____ City:_____ State:_____ Zip _____

Home Phone #:_____ Work Phone #:_____ Other Phone #s: _____

Referred By:_____

Employer:_____ Occupation: _____

Employer's Address:_____ City:_____ State:_____ Zip _____

Status: Single Married Divorced Separated Widowed Spouse/Life Partner's Name:_____

If you are completing this form for another person, what is your relationship to that person? _____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Active Tuberculosis	❒	❒	❒
Persistent cough greater than a 3 week duration	❒	❒	❒
Cough that produces blood	❒	❒	❒
Been exposed to anyone with tuberculosis	❒	❒	❒

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

MEDICAL HISTORY

Physician's Name:_____ Phone:_____

Have you had any serious illnesses or operations? ❒ Y ❒ N If yes, describe_____

Are you currently under physician care? ❒ Y ❒ N If yes, describe _____

Have you ever had a blood transfusion? ❒ Y ❒ N If yes, approximate dates_____

Have you ever taken Fosamax or any other osteoporosis drug? ❒ Y ❒ N Have you ever taken Fen-Phen/Redux? ❒ Y ❒ N

Women: Are you pregnant? ❒ Y ❒ N

Check (√) yes or no if you have had problems with any of the following:

❒ Y ❒ N AIDS/HIV Positive
❒ Y ❒ N Anaphylaxis
❒ Y ❒ N Anemia
❒ Y ❒ N Arthritis, Rheumatism
❒ Y ❒ N Artificial heart valves
❒ Y ❒ N Artificial joints
❒ Y ❒ N Asthma
❒ Y ❒ N Back problems
❒ Y ❒ N Blood disease
❒ Y ❒ N Cancer
❒ Y ❒ N Chemical dependency
❒ Y ❒ N Chemotherapy
❒ Y ❒ N Circulatory problems
❒ Y ❒ N Cortisone treatments
❒ Y ❒ N Cough, Persistent
❒ Y ❒ N Cough up blood
❒ Y ❒ N Diabetes
❒ Y ❒ N Eczema
❒ Y ❒ N Epilepsy
❒ Y ❒ N Fainting
❒ Y ❒ N Food allergies
❒ Y ❒ N Glaucoma
❒ Y ❒ N Headaches
❒ Y ❒ N Heart murmur
❒ Y ❒ N Heart problems
Describe_____
❒ Y ❒ N Hemophilia/Abnormal bleeding
❒ Y ❒ N Herpes
❒ Y ❒ N Hepatitis
❒ Y ❒ N High blood pressure
❒ Y ❒ N Jaw pain
❒ Y ❒ N Kidney disease/malfunction
❒ Y ❒ N Liver disease
❒ Y ❒ N Material allergies (latex, wool, metal, chemicals)
❒ Y ❒ N Mitral valve prolapse
❒ Y ❒ N Nervous problems
❒ Y ❒ N Pacemaker/heart surgery
❒ Y ❒ N Psychiatric care
❒ Y ❒ N Rapid weight gain or loss
❒ Y ❒ N Radiation treatment
❒ Y ❒ N Respiratory disease
❒ Y ❒ N Rheumatic/Scarlet fever
❒ Y ❒ N Shingles
❒ Y ❒ N Shortness of breath
❒ Y ❒ N Stroke
❒ Y ❒ N Surgical implant
❒ Y ❒ N Swelling of feet/ankles
❒ Y ❒ N Thyroid disease/malfunction
❒ Y ❒ N Tobacco habit
❒ Y ❒ N Tonsillitis
❒ Y ❒ N Tuberculosis
❒ Y ❒ N Ulcer/Colitis
❒ Y ❒ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any drug allergies? ❒ Y ❒ N

List allergies:

_____

_____

OFFICE USE ONLY

Date	Change	Initial

Dental Information (Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do your gums bleed when you brush or floss?	❒	❒	❒
Are your teeth sensitive to cold, hot, sweets or pressure?	❒	❒	❒
Does food or floss catch between your teeth?	❒	❒	❒
Is your mouth dry?	❒	❒	❒
Have you had any periodontal (gum) treatments?	❒	❒	❒
Have you ever had orthodontic (braces) treatment?	❒	❒	❒
Have you had any problems associated with previous dental treatment?	❒	❒	❒
Is your home water supply fluoridated?	❒	❒	❒
Do you drink bottled or filtered water?	❒	❒	❒
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❒	❒	❒

What is the reason for your dental visit today?

_____

_____

_____

	Yes	No	DK
Do you have earaches or neck pains?	❒	❒	❒
Do you have any clicking, popping or discomfort in the jaw?	❒	❒	❒
Do you grind your teeth?	❒	❒	❒
Do you have sores or ulcers in your mouth?	❒	❒	❒
Do you wear dentures or partials?	❒	❒	❒
Do you participate in active recreational activities?	❒	❒	❒
Have you ever had a serious injury to your head or mouth?	❒	❒	❒
Have you experienced persistent bad breath?	❒	❒	❒
Do you snore?	❒	❒	❒

Date of your last dental exam _____

What was done at that time? _____

_____

_____

Date of last dental x-rays _____

_____

How often do you brush? _____ Floss _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❒ Y ❒ N

Other information about your dental health or previous treatment _____

_____

Account Info.

Person ultimately responsible for account:

Name: _____ Relation: _____

Billing Address: _____ City _____ State _____ Zip _____

Work Phone #: _____

Payment method: ❒ Cash ❒ Check ❒ Credit Card

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
Initials I fully understand I am solely responsible for any balance not paid by my insurance company.

In event of emergency:

Who should we contact? _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Who is your medical doctor? _____ MD's Phone: _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date _____ / _____ / _____

❒ Adult Patient ❒ Spouse