≪ Jagor and Jagor, D.D.S. ∞

Welcome to our office. Please fill out <u>both sides</u> of this *confidential* information form

Personal information:								
Name (Dr. Mr. Mrs. Ms.) (Preferred first name)								
(Dr. Mr. Mrs. Ms.) (Preferred first name)	(Last name) (Legal first name)							
Home address	Date of birth							
	_ Sex O Male O Female							
(City) (State) (Zip)	_ Social Security number							
Home phone	_ Office phone							
Cell phone	_ E-mail							
Employer name	_ Spouse employer name							
If full time student, Where?	_ Spouse office phone							
Who referred you to our office?								
Primary reason for your visit today?								
When was your last visit to a dentist?								
When was your last full mouth x-ray taken?								
Financial information								
Person responsible for your dental expenses	f different than above) (Phone)							
(Address if different than above)	(City) (State) (Zip)							
Dental insurance: O Self O Spouse O Other	O Secondary insurance							
Birth Date of Policy Holder: Birth Date of Policy Holder:								
Social Sec. # of Policy Holder:	Holder: S.S. # of Policy Holder:							
Ins. Company name	Secondary Ins. Co. name							
Policy or group number	Policy or group number							
Please present your insurance card so we may copy it								

Please turn over for medical history

Medical History Information

Please check yes or no to the following

Yes	No		Yes	No		Yes	No	
0	0	Abnormal bleeding	0	0	Epilepsy	0	0	Low blood pressure
0	0	Anemia	0	Ο	Fever blisters	0	0	Mitral valve prolapse
0	0	Artificial joints	0	0	Heart murmur	0	0	Radiation treatment
0	0	Artificial heart valve	0	0	Hemophilia	0	0	Rheumatic fever
0	0	Asthma	0	0	Hepatitis A, B, or C	0	0	Seizures
0	0	Cancer	0	0	Herpes	0	0	Sinus problems
0	0	Chemotherapy	0	0	High blood pressure	0	0	Steroid therapy
0	0	Congenital heart defect	0	0	HIV/Aids	0	0	Tuberculosis
0	0	Diabetes	0	0	Kidney problems	0	0	Ulcers
0	0	Emphysema	0	0	Liver disease	0	0	Low bone density
0	0	Bone enhancing Medicine	0	0	Surgical Implant	0	0	Headaches
Phy	sicia	ns name			Phone numb	er		
Are	you	allergic to latex? O Yes O	No	Ar	e you allergic to any med	licatior	n? C	Yes O No
If ye	s, pl	ease list.						
Are	you	currently under the care of a	physi	cian	? O Yes O No			
		assa avnlain						
Plea	se li	st any medications you are cu	rrentl	y ta	king			
Are	you	pregnant? O Yes ONo		Dı	le date			

Please read the following before signing as it contains important policies regarding our office.

- ✤ I affirm that the above information is correct to the best of my knowledge.
- I understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical or insurance status.
- I authorize the release of necessary medical information to my insurance company and I authorize them to remit payment directly to the dentist.
- I understand that as a courtesy this office will file my insurance for me but I am responsible for payment of services rendered including any portion not covered by my insurance carrier. In addition this office may charge 1% interest per month on all overdue accounts.
- ★ I acknowledge that I have received a copy of this offices notice of privacy practices.
- ★ I authorize this office to perform necessary dental treatment with my informed consent.

Signature of patient or guardian

Date

Future medical updates

I have reviewed the above infor	mation and hav	ve informed this office of an	y changes.
1		2	
Signature	Date	Signature	Date
3		4	
Signature	Date	Signature	Date
5		6	
Signature	Date	Signature	Date