

Bruce Jones Dentistry
7255 Joshua Lane
Yucca Valley, CA 92284

760.365.8331

Welcome to our office. Please print your answers to the following questions in order to assist us to help you.
Your information is private and protected.

Name _____
Birthdate _____ SS No _____
Mailing address _____
City _____ State _____ ZIP _____
Phone (cell) _____ (home) _____ (work) _____
Email address _____
Employer _____ Phone _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? (If self, skip to next section)

Name _____
Relation _____ Birthdate _____ SS No _____
Mailing address _____
City _____ State _____ ZIP _____
Phone (cell) _____ (home) _____ (work) _____
Email address _____
Employer _____ Phone _____

PRIMARY DENTAL INSURANCE

Insured Name _____	Ins. Name _____
Birthdate _____ SS No _____	Ins. Address _____
Employer _____	City _____ State _____ ZIP _++_
Emp. Address _____	Ins. Phone _____ Ext. _____
City _____ State _____ ZIP _____	Group No. _____ Plan _____

SECONDARY DENTAL INSURANCE

Insured Name _____	Ins. Name _____
Birthdate _____ SS No _____	Ins. Address _____
Employer _____	City _____ State _____ ZIP _____
Emp. Address _____	Ins. Phone _____ Ext. _____
City _____ State _____ ZIP _____	Group No. _____ Plan _____

IN CASE OF EMERGENCY

Name _____
Relation _____ Phone _____
Physician _____ Phone _____

HEALTH HISTORY

Although we will be focusing on your mouth, health problems that you may have or medications you may be taking could have an important effect on the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Has there been any change in your general health within the past year? _____

Physician's name _____ Phone _____

Do you have ____ active tuberculosis? ____ persistent cough greater than 3 weeks duration?
____ cough that produces blood? **If yes, please stop and return this form to the receptionist.**

ALLERGIES (please circle)

Local anesthetic	Aspirin	Other medications
Penicillin	Codeine or other narcotics	Latex
Other antibiotics	Barbituates, sedatives, or sleeping pills	

Please list any allergies other than drug allergies _____

PREMEDICATION (some conditions require antibiotics be taken for some dental procedures)

Have antibiotics for dental treatment been recommended? _____

Have you been told you have/ had Rheumatic fever, damaged heart valves, heart defects, a heart murmur, or mitral valve prolapse? _____

Do you have a prosthetic joint/ implant? _____

Physician who placed _____ Phone _____

Do you have a transplant? _____

HAVE OR HAD? (please circle)

Heart attack(s)	Anemia	Diabetes
Stroke	Abnormal bleeding	Low blood sugar
	Bruise easily	Osteoporosis
	Ulcers	Arthritis
High blood pressure	Hemophilia	Smoking, snuff, chew
Low blood pressure		Acid reflux
Chest pain/ angina	Hepatitis	Aids or HIV infection
Irregular heart beat	Liver problems	
Pacemaker	Kidney problems	Bronchitis, chronic cough
	Thyroid problems	Asthma
Epilepsy	Glaucoma	Hay fever/ sinus problems
Fainting spells		Snoring/ sleep apnea
Migranes	Chemotherapy	Difficulty breathing
	Radiation therapy	Emphysema

WOMEN: Taking birth control pills Possibility of pregnancy Pregnant Breast feeding

MEDICATIONS

Please list any medications you are currently taking: _____

Are you taking any over-the-counter medicines? _____

Are you taking any natural product, herbal supplement, or homeopathic remedy? _____

Are you NOT taking any medications that have been prescribed for you? _____

DENTAL INFORMATION

What is your main concern with your teeth? _____

(please circle where applicable)

Bad breath or taste

Sensitive teeth

Clenching or grinding

Bleeding gums

Pain around ear

Frequent headaches

Difficulty chewing food

Dry mouth

Other

Long-term goals _____

Any trouble with previous dental treatment? _____

ORAL HYGIENE: what do you use?

_____ toothbrush

_____ floss

_____ interdental stimulators

_____ automatic toothbrush

_____ toothpicks

_____ water jet device

_____ fluoride supplements or gels

_____ other

FEAR: please indicate (0 = none, 1 = mild, 2 = moderate, 3 = severe, 4 = disabling panic)

___ calling for an appointment

___ sitting in dental chair

___ having an injection

___ waiting in the reception room

___ having teeth x-rayed

___ having teeth drilled

___ smell of dental office

___ seeing dental instruments

___ having an extraction

___ seeing the dentist

___ having a cleaning

___ losing control

AUTHORIZATION

I authorize my dentist and his designated staff to perform an oral examination for the purpose of diagnosis and treatment planning including the taking of all xrays as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

FEES & PAYMENTS

I understand an estimate of the charge for any procedure I may require will be given to me upon request.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that dental insurance is a method of reimbursement for fees paid to the doctor, and my insurance carrier may pay less than the actual bill for services.

SIGNATURE ON FILE

This signature on file is my authorization for the release of information necessary to process my claim.

I hereby authorize payment to this doctor of the benefits otherwise payable to me.

Signature _____ Date _____
(parent or guardian, if a minor)

Witness name _____
Signature _____ Date _____