ID: _____

Chart ID: _____

Jamaica College Dental Form

First Name: _____ Last Name: _____ Middle Initial: _____

Patients Is: ◯ Policy Holder ◯ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home phone: _____ Work phone: _____ Ext: _____ Cell Phone: _____

D.O.B: _____ TRN: _____ Driver's Lic: _____

☐ Responsible Party is also a Policy Holder for the Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ Parish/State/ Zip: _____

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

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

D.O.B: _____ Age: _____ TRN: _____ Driver Lic: _____

Email: _____ ☐ I would like to receive correspondences via email.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medical ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Referred by: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured TRN: _____ Insured D.O.B: _____

Employer: _____

Address: _____

Address 2: _____

City/Parish/Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City/Parish/Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured TRN: _____ Insured D.O.B: _____

Employer: _____

Address: _____

Address 2: _____

City/Parish/Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City/Parish/Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now? ◯ Yes ◯ No If Yes _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If Yes _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If Yes _____

Are you taking any medication, pills or drugs? ◯ Yes ◯ No If Yes _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If Yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing, bisphosphonates? ◯ Yes ◯ No If Yes _____

Do you use tobacco? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Local anesthetic

WOMEN: Are you…. ◯ Pregnant/ Trying to get pregnant ◯ Nursing ◯ Taking oral contraceptive

Do you use controlled substances? ◯ Yes ◯ No If Yes _____

Others

Do you have, or have you had, any of the following*

AID/HIV Positive	◯ Yes	◯ No	Cortisone Medication	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Epilepsy or Seizure	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No	Artificial Heart Valve	◯ Yes	◯ No
Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No	Artificial Point	◯ Yes	◯ No
Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No	Asthma	◯ Yes	◯ No
Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No	Blood Disease	◯ Yes	◯ No
Kidney Problems	◯ Yes	◯ No	Blood Transfusion	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Lung Disease	◯ Yes	◯ No	Thyroids Disease	◯ Yes	◯ No	Chemotherapy	◯ Yes	◯ No
Chest Pain	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Heart Pacemaker	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No	Convulsions	◯ Yes	◯ No
Psychiatric Care	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Renal Disease	◯ Yes	◯ No	Angina	◯ Yes	◯ No	Arthritis/Gout	◯ Yes	◯ No
Excessive Bleeding	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Faint Spells/Dizziness	◯ Yes	◯ No
Frequent Cough	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Congenital Heart Disease	◯ Yes	◯ No	Heart Trouble/ Disease	◯ Yes	◯ No			

Have you ever had any serious illness not listed ◯Yes ◯No If Yes _____

Comments!

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian!

X_____ Date: _____