

JACY C. NELSON, DDS, PS

Name Birthdate Sex: Male Female
Address Employer
City Zip Code Occupation SS#
Mailing Address (if different) Are you covered by insurance? Yes No
Home Phone Work Phone Who may we thank for sending you?
Driver's License Number Email Address

MEDICAL AND DENTAL INFORMATION

Do you have or have you had any of the following:

Table with 3 columns of symptoms (a-i, j-r, s-z) and 2 columns of Yes/No checkboxes.

Explanation of above answers

Reason for today's visit

How long since last medical exam? How long since last dental cleaning/exam?

List any medications you are taking

Have you ever taken: Phen-Fen? Fosamax/Actonel (for osteoporosis)? IV Bisphosphanates (for cancer)?

Have you experienced any allergic or unusual reaction to: Penicillin Aspirin Codeine Dental Anesthetic Other

Physician name Physician phone

Do you or have you had any illnesses or health problems not listed above that we should know about?

WOMEN: Are you or could you be pregnant? If yes, which trimester?

Grid of questions about dental apprehension, gagging, gum bleeding, tooth sensitivity, and clenching with Yes/No checkboxes.

Permit for treatment and surgical care: I hereby grant permission to the staff of Jacy C. Nelson, DDS, PS to employ such established treatments and therapy as may be deemed professionally necessary or advisable.

FINANCIAL AGREEMENT: All charges for services and treatment will be paid upon completion of appointment. All outstanding balances over 90 days shall accrue interest at the rate of 1% per month.

IF INSURANCE IS INVOLVED: I hereby authorize payment directly to Jacy C. Nelson, DDS, PS otherwise payable to me.

I hereby certify that the above information is true and correct to the best of my knowledge.

PATIENT/GUARDIAN/GUARANTOR'S SIGNATURE DATE

HEALTH HISTORY REVIEW

Table with 3 columns: Date, Changes, Initial. Multiple rows for recording health history.