PATIENT INFORMATION

First Name ______________M.I.____ Last________________________ Gender: ☐M ☐F ☐Neutral
Date of Birth_______________ Soc. Sec. #____________________ Driver Lic. #__________________________________
Address_____________________________________City_________________State__________Zip_______________
Email______________________________ Home phone#__________________________ Cell#_____________________
Employer____ Work #___________________________________
Emergency Contact____ Phone #___________________________________

PRIMARY INSURANCE

Insurance Type: ☐**Dental** ☐**Medical**

Subscriber name________________________________
Relation_______________________________________
Gender: ☐M ☐F ☐Neutral Date of Birth__________
Address____
City_____________ State_________ Zip___________
Phone #______________ Soc. Sec. #_______________
ID#____
Employer_______________________________________
Insurance Co. Name _____________________________
Claims Address__________________________________
City_____________ State_________ Zip___________
Customer Service Phone #________________________
Group #______________Group name______________

SECONDARY INSURANCE

Insurance Type: ☐**Dental** ☐**Medical**

Subscriber name________________________________
Relation_______________________________________
Gender: ☐M ☐F ☐Neutral Date of Birth__________
Address____
City_____________ State_________ Zip___________
Phone #______________ Soc. Sec. #_______________
ID#____
Employer_______________________________________
Insurance Co. Name _____________________________
Claims Address__________________________________
City_____________ State_________ Zip___________
Customer Service Phone #________________________
Group #______________Group name______________

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Janssen or her designated staff to take x-rays, study models, photographs and other diagnostics as deemed appropriate for diagnosis of my dental needs.
2. Upon diagnosis, I authorize Dr. Janssen or her designated staff to perform any recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medications where necessary. I understand I can ask for a complete recital of any possible complications.

Patient Signature (Parent/guardian if a minor) X___________________________________ date______________

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.

Patient Signature (Parent/guardian if a minor) X___________________________________ date______________

DENTAL HISTORY – Circle "Yes" or "No" if you have or have had any of the following:

Oral Tissues & Conditions	
Bad breath / halitosis	Y / N
Sores or growths in mouth	Y / N
Bleeding gums	Y / N
Periodontal (gum) disease	Y / N

Treatments Considerations	
Dental anxiety	Y / N
Excessive gag reflex	Y / N
Difficult to get numb	Y / N
Claustrophobic	Y / N
Difficulty opening mouth	Y / N

Trauma, Treatment, & Appliances	
Injury to face / jaw *Yr?*___	Y / N
Bite guard / sports guard	Y / N
Ortho: braces, Invisalign,etc. *Yr?*___	Y / N
Oral surgery *Yr?*___	Y / N
Partial / full dentures	Y / N

Respiration Related	
Dry mouth	Y / N
Mouth breathing	Y / N
Snoring	Y / N
Sleep apnea	Y / N
C-Pap machine	Y / N
Sleep study	Y / N

TMJ Symptoms & Treatments	
Frequent headaches/neckaches	Y / N
Clicking or popping jaw	Y / N
Tired, sore, or painful jaw joint	Y / N
Pain around ears / temples	Y / N
Clenching or grinding of teeth	Y / N
TMJ Treatment	Y / N
Nightguard / NTI	Y / N

Tooth Issues	
Pain with chewing	Y / N
Food packing between teeth	Y / N
Broken tooth or filling	Y / N
Sensitivity (hot, cold, sweet, biting)	Y / N
Vague ache / toothache	Y / N
Swelling	Y / N
Loose tooth	Y / N

MEDICAL HISTORY FORM

Name ________________________________ Date of Birth__________ Today's date______________

Please complete all the questions on this page and circle "Yes" or "No" as indicated. Your answers are confidential.

Who is your primary medical physician?____

When was your last physical exam?____

In the past five years, have you had any serious illness, operations, or been hospitalized? Y / N

If Yes, describe____

List all prescription drugs, non-prescription drugs, vitamins, or supplements you currently take:

____

____

Are you allergic or have you had an adverse reaction to:

Codeine / Demerol	Y / N	Aspirin / Acetaminophen / Ibuprofen	Y / N
Sulfa drugs	Y / N	Penicillin / Erythromycin / Tetracycline / other antibiotics	Y / N
Latex	Y / N	*List other allergies:*	
Metals of any kind	Y / N	______________________________	
Local anesthetic	Y / N	______________________________	

Heart Conditions

Angina/chest pain (on exertion)	Y / N
Artificial valves	Y / N
Heart valve problems	Y / N
Heart attack / disease / surgery	Y / N
Heart murmur	Y / N
High/low blood pressure	Y / N
Pacemaker	Y / N
Rheumatic Fever	Y / N
Infective (bacterial) Endocarditis	Y / N

Liver Problems

Fatty Liver disease	Y / N
Liver disease	Y / N
Hepatitis A, B, C, D, or E	Y / N

Oncologic Problems / Treatment

Cancer *(type______________)*	Y / N
Chemotherapy	Y / N
Radiation therapy	Y / N

Thyroid / Pancreas / Kidney Problems

Hyperthyroidism	Y / N
Hypothyroidism	Y / N
Diabetes Type I or Type II	Y / N
Slow healing	Y / N
Kidney disease	Y / N

Bacterial & Viral Infections / STD / STI

Chicken Pox / Shingles	Y / N
Oral herpes (cold sores)	Y / N
Human Papillomavirus (HPV)	Y / N

Blood Disorders

Bleeding / clotting issue	Y / N
Anemia	Y / N
Blood transfusion	Y / N

Respiratory Problems

Asthma	Y / N
Allergies / sinus	Y / N
Sinus problems	Y / N
Lung problems	Y / N
Shortness of breath	Y / N
Tuberculosis	Y / N
Emphysema / COPD	Y / N

Digestive Problems

Acid Reflux / G.E.R.D. / Hyperacidity	Y / N
Ulcer(s)	Y / N
Weight loss	Y / N

Joint Problems

Artificial joint / Joint replacement	Y / N
Arthritis	Y / N
Back problems	Y / N

Nervous System Problems

Epilepsy	Y / N
Dizziness / vertigo	Y / N
Neurological disorder(s)	Y / N
Psychological disorder(s)	Y / N
Anorexia / bulimia	Y / N

Immune System Problems

Autoimmune Disease *(type______________)*	Y / N
HIV / AIDS	Y / N

Substance Use

Alcohol / substance abuse	Y / N
Tobacco (smoking, chewing, vaping)	Y / N
Marijuana (any form)	Y / N
Other substances ______________	Y / N

Do you have, or have you had, any other medical conditions that were not addressed above? ____________________