PARK PLACE
DENTAL
Advanced, Comfort Conscious Dentistry

Michael W Jones, DDS

PATIENT INFORMATION FORM

About You

Name_____
Preferred name_____ ☐Male ☐Female
☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Birthdate___/___/___ Age___ Soc Sec #_____
Address_____
City_____State_____Zip_____
Email_____Drivers Lic._____
Home #_____ Work #_____
Mobile #_____ Fax #_____
Whom may we thank for referring you?_____
Other family members seen by us?_____
Last dental visit_____
Employer_____
Employer Phone #_____How long there?___

Account Info

PERSON RESPONSIBLE FOR ACCOUNT
Name_____Relationship_____
Address_____
City_____State_____Zip_____
Email_____
Home #_____ Work #_____
Mobile #_____ Birthdate___/___/_____

Spouse Info

Name_____
Home #_____ Work #_____
Mobile #_____ Birthdate___/___/_____
Email_____

Insurance

PRIMARY
Provider Name_____
Provider Address_____
City_____State_____Zip_____
Group #_____
Policy holder name _____
Relationship to patient_____
Policy holder Birthdate___/___/___ ID#_____
Policy holder employer _____
Policy holder phone #_____
SECONDARY
Provider Name_____
Provider Address_____
City_____State_____Zip_____
Group #_____ID#_____
Policy holder name _____
Relationship to patient_____
Policy holder phone #_____ Birthdate___/___/___
Policy holder employer _____

I have been offered/received a copy of the HIPAA Privacy Practices and Dental Materials Fact Sheet.
I understand that Dr. Michael Jones office abides by the HIPAA law and will protect the privacy of my personal information.

_____ _____
Signature of Patient/Guardian Date

_____Individual Refused to Sign _____Communication Barriers Prohibited us from obtaining acknowledgement

131 Lynch Creek Way, Suite A
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Phone: 707-763-3525

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PATIENT INFORMATION FORM

Medical History

Current physical condition ☐Good ☐Fair ☐Poor
Do you smoke or use tobacco in any form? Yes No
Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No
Please list each one_____
Have you ever taken Bisphosphonate? Yes No
(Also known as Fosamax) If yes, when_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes/Fever Blisters
Yes	No	Alcohol/Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Anemia	Yes	No	HIV+/AIDS
Yes	No	Arthritis	Yes	No	Hospitalize
Yes	No	Artificial Bones, Joints or Valves	Yes	No	Kidney Problems
			Yes	No	Liver Disease
Yes	No	Asthma	Yes	No	Low Blood Pressure
Yes	No	Blood Transfusion	Yes	No	Lupus
Yes	No	Cancer/Chemo	Yes	No	Mitral Valve Prolapse
Yes	No	Colitis	Yes	No	Pacemaker
Yes	No	Cong. Heart Defect	Yes	No	Psychiatric Problems
Yes	No	Diabetes	Yes	No	Radiation Treatment
Yes	No	Difficulty Breathing	Yes	No	Rheumatic/Scarlet Fever
Yes	No	Emphysema			
Yes	No	Epilepsy	Yes	No	Seizures
Yes	No	Fainting Spells	Yes	No	Shingles
Yes	No	Frequent Headaches	Yes	No	Sickle Cell Disease
Yes	No	Glaucoma	Yes	No	Sinus Problems
Yes	No	Hay Fever	Yes	No	Stroke
Yes	No	Heart Attack	Yes	No	Thyroid Problems
Yes	No	Heart Murmur	Yes	No	Tuberculosis (TB)
Yes	No	Heart Surgery	Yes	No	Ulcers
Yes	No	Hemophilia	Yes	No	Venereal Disease
Yes	No	Hepatitis			

Please list any medical conditions(s) that you have ever had:
_____
_____

FOR WOMEN ONLY
Are you taking birth control pills? Yes No
Are you pregnant? Yes No
Are you nursing? Yes No

ALLERGIES TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Codeine
Yes	No	Dental Anesthetics	Yes	No	Erythromycin
Yes	No	Jewelry/metals	Yes	No	Latex
Yes	No	Penicillin	Yes	No	Tetracyclin
Yes	No	Other			

Please list any allergies that you have ever had:
_____
_____

Medical Info

Do you have a personal physician? Yes No
Physician's Name _____
Phone# _____ Last visit _____
Are you currently under physician's care? Yes No
Please explain _____
EMERGENCY CONTACT INFORMATION:
Name _____ Relation _____
Home# _____Work# _____

Dental History

Why have you come to the dentist today?
_____
Has your doctor told you that you require antibiotics before dental treatment? Yes No
Are you currently in pain? Yes No
Have you ever had a serious/difficult problem associated with any previous dental work? Yes No
Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No
Current dental health ☐Good ☐Fair ☐Poor
Do you like your smile? Yes No
Do your gums ever bleed? Yes No

FOR COMPLETION BY DENTIST:
_____
_____
_____

_____ _____
Doctor signature Date

_____ _____
Signature of Patient or Guardian Date