

Welcome...

John Baron DDS A PROFESSIONAL DENTAL CORPORATION
GENERAL AND COSMETIC DENTISTRY

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out
this form completely in ink. If you have any questions or need
assistance, please ask us - we will be happy to help you.

Patient Information (CONFIDENTIAL)

Date _____
Soc. Sec. # _____
Drivers Lic. # _____
Name _____ Birthdate _____ Home Phone _____
FIRST MIDDLE LAST
Address _____ City _____ State _____ Zip _____
Employed by _____ Occupation _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Female Male Is Patient: Married Single Child
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
Person to Contact in Case of Emergency _____ Phone _____
Whom may we thank for referring you? _____

Responsible Party / Primary Insurance Information

Name of Person Responsible for this Account _____
FIRST MIDDLE LAST
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Work Phone _____
Insurance Company _____ Group # _____
Drivers License # _____

Spouse or Secondary Insurance Information

Is Patient Covered by Insurance?: Yes No Drivers License # _____
Soc. Sec. # _____
Name _____ Relation to Patient _____ Birthdate _____
FIRST MIDDLE LAST
Address (If different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Employed by _____ Occupation _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____

Please Complete Both Sides

Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of Last Dental Care _____ Date of Last Dental X-Rays _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores or Growths in your Mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No Have you taken Phen Fen? Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Check (✓) if you have had problems with any of the following:

- | | | | |
|--------------------------------------------------|-----------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| | | | <input type="checkbox"/> Disease or Condition |

MEDICATIONS

List Medications you are currently taking

ALLERGIES

- Penicillin
 Local-Anesthetic
 Latex
 Any Other _____

not Listed _____

Our office requires a 24-Hour Notice to change an appointment. If you do not show up for your appointment or do not call us at least 24 hours ahead of your appointment to cancel, or request a change in the planned treatment, you will be charged \$25.⁰⁰ per half-hour of schedule time. All returned checks incur a \$25.⁰⁰ fee. The patient/guardian agrees to be and is fully responsible for total treatment of service performed in this office including any amounts not covered by any dental/medical insurance. You will receive a monthly statement regardless of whether or not you have insurance to inform you of the status of your account. A 1^{1/2}% per month finance charge will be assessed on any balance over 90 days old. I AUTHORIZE THE DOCTOR TO EXAMINE ME, OBTAIN NECESSARY DIAGNOSTIC INFORMATION, OBTAIN CREDIT BUREAU REPORT, AUTHORIZE MY EMPLOYER TO VERIFY EMPLOYMENT, AND RENDER TREATMENT. I ALSO UNDERSTAND AND AGREE TO THE ABOVE OFFICE POLICIES.

Patient's Signature or Signature if Minor _____

Date _____