



**JORDAN FAMILY
DENTISTRY**
Robert J. Jordan D.D.S

We are pleased to welcome you to our practice. It is our goal to provide you with the best dental care possible. Please take a few minutes to complete this form. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Last _____ First _____ Middle _____ Soc. Sec. # _____

Address _____ Phone _____

City _____ State _____ Zip _____ Cell _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employer _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

DENTAL INSURANCE

PRIMARY INSURANCE

Person Responsible for Account _____ Last _____ First _____ Middle _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Other dependents under plan _____

SECONDARY INSURANCE

Subscriber Name _____ Relation _____ Birthdate _____

Address (If different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Phone _____

Employer _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Other dependents under plan _____

DENTAL HISTORY

What would you like us to do today? _____ Are you in discomfort? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental appointment _____

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

- | | | | |
|---|--|---|--|
| <input type="radio"/> Bad breath | <input type="radio"/> Food collection between teeth | <input type="radio"/> Periodontal treatment | <input type="radio"/> Sensitivity to sweets |
| <input type="radio"/> Bleeding gums | <input type="radio"/> Grinding or clenching teeth | <input type="radio"/> Sensitivity to cold | <input type="radio"/> Sensitivity chewing |
| <input type="radio"/> Clicking or popping jaw | <input type="radio"/> Loose teeth or broken fillings | <input type="radio"/> Sensitivity to hot | <input type="radio"/> Sores/growths in mouth |

How often do you brush? _____ Floss? _____ Do you like the appearance of your teeth? _____

Please complete both sides

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of last medical visit _____ Have you been hospitalized or had a serious illness? Y N _____

Are you currently under a physician's care? Y N If yes, please describe _____

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

<p>HEART/BLOOD VESSELS</p> <p>Rheumatic fever/Heart disease.....Y N</p> <p>Heart valve damage.....Y N</p> <p>Heart murmur.....Y N</p> <p>Congenital heart defect.....Y N</p> <p>Artificial heart valve.....Y N</p> <p>Prolapsed heart valve.....Y N</p> <p>High blood pressure.....Y N</p> <p>Heart attack (Date).....Y N</p> <p>TIA/Stroke (Date).....Y N</p> <p>Heart Surgery (Date).....Y N</p> <p>Congestive heart failure.....Y N</p> <p>Angina/Chest pain.....Y N</p> <p>Irregular/Rapid heart beats.....Y N</p>	<p>Anxiety/Depression.....Y N</p> <p>Alzheimer's disease/Dementia..Y N</p> <p>Psychiatric treatment.....Y N</p> <p>Persistent dizziness/Fainting....Y N</p> <p>Other _____</p> <p>HEAD AND NECK</p> <p>Glaucoma.....Y N</p> <p>Chronic sinusitis.....Y N</p> <p>Injury to head, neck, jaw or teethY N</p> <p>Headaches.....Y N</p> <p>TMJ (temporomandibular joint) disorderY N</p> <p>Persistent sore throat.....Y N</p> <p>Difficulty swallowing.....Y N</p> <p>ENDOCRINE</p> <p>Diabetes.....Y N</p> <p>Thyroid condition.....Y N</p> <p>Other _____</p> <p>MUSCULOSKELETAL</p> <p>Arthritis.....Y N</p> <p>Artificial joint (Date).....Y N</p> <p>Fibromyalgia/Rheumatism.....Y N</p> <p>Chronic back or neck pain.....Y N</p>	<p>RESPIRATORY</p> <p>Tuberculosis (TB).....Y N</p> <p>Asthma.....Y N</p> <p>Emphysema.....Y N</p> <p>Persistent cough.....Y N</p> <p>Shortness of breath.....Y N</p> <p>Smoke.....Y N</p> <p>URINARY TRACT</p> <p>Kidney disease.....Y N</p> <p>Dialysis.....Y N</p> <p>Venereal disease.....Y N</p> <p>STD.....Y N</p> <p>DIGESTIVE SYSTEM</p> <p>Hepatitis..Type: A B C D N</p> <p>Ulcers.....Y N</p> <p>Jaundice.....Y N</p> <p>Frequent heartburn/reflux.....Y N</p> <p>Frequent nausea/vomiting.....Y N</p> <p>CANCER HISTORY</p> <p>Cancer (Date).....Y N</p> <p>If yes, what type? _____</p> <p>Leukemia.....Y N</p> <p>Benign tumors/growths.....Y N</p> <p>Other _____</p>	<p>ALLERGY HISTORY</p> <p>Are you allergic to or have you ever had a bad reaction to any of the following?</p> <p>Dental Anesthetics.....Y N</p> <p>Penicillin.....Y N</p> <p>Sulfa Drugs.....Y N</p> <p>Other Antibiotics _____</p> <p>Aspirin.....Y N</p> <p>Latex products.....Y N</p> <p>Other _____</p> <p>MISCELLANEOUS</p> <p>Lupus erythematosus.....Y N</p> <p>Organ transplant.....Y N</p> <p>_____</p> <p>Suppressed immune system.....Y N</p> <p>Taken Steroid/Prednisone.....Y N</p> <p>Taken prescription diet pills.....Y N</p> <p>WOMEN</p> <p>Are you pregnant?.....Y N</p> <p>Due Date _____</p> <p>Are you breast feeding?.....Y N</p> <p>Are you in or have you passed through menopause?.....Y N</p> <p>Do you take birthcontrol/hormones?Y N</p>
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Do you have any other condition that you think we should know about? Y N _____

Please list any medications you are currently taking. _____

HEALTH UPDATES *DENTAL STAFF TO FILL OUT: Update annually; or more often as indicated.*

<p>1 UPDATE - Since your last visit:</p> <p>1. Have you seen a medical doctor?.....Y N</p> <p>2. Have you had any change in your medication?.....Y N</p> <p>3. Have you had a change in your medical condition or had surgery?.....Y N</p> <p><i>Please note changes in health since last visit. If no change - please write "None".</i></p> <p>_____</p> <p>Date _____ Signature _____</p>	<p>3 UPDATE - Since your last visit:</p> <p>1. Have you seen a medical doctor?.....Y N</p> <p>2. Have you had any change in you medication?.....Y N</p> <p>3. Have you had a change in your medical condition or had surgery?.....Y N</p> <p><i>Please note changes in health since last visit. If no change - please write "None".</i></p> <p>_____</p> <p>Date _____ Signature _____</p>
<p>2 UPDATE - Since your last visit:</p> <p>1. Have you seen a medical doctor?.....Y N</p> <p>2. Have you had any change in you medication?.....Y N</p> <p>3. Have you had a change in your medical condition or had surgery?.....Y N</p> <p><i>Please note changes in health since last visit. If no change - please write "None".</i></p> <p>_____</p> <p>Date _____ Signature _____</p>	<p>4 UPDATE - Since your last visit:</p> <p>1. Have you seen a medical doctor?.....Y N</p> <p>2. Have you had any change in you medication?.....Y N</p> <p>3. Have you had a change in your medical condition or had surgery?.....Y N</p> <p><i>Please note changes in health since last visit. If no change - please write "None".</i></p> <p>_____</p> <p>Date _____ Signature _____</p>

AUTHORIZATION

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof: Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ Date: _____ Relationship: _____