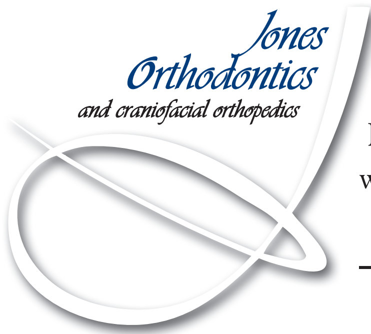

20 Pidgeon Hill Drive, Suite 206, Sterling, VA 20165
Phone: 703-421-0893, Fax 703-421-0897
www.jones4smiles.com

Member American Association of **Orthodontists**
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

Tell us About Your Child

Child's Name: ______________________

Child's Birthdate: ______________ Age: ________

Sex: [ ] M [ ] F SS#: ______________________

School: ______________________

Who is accompanying the child today?

Name: ________________ Relation: ________

Do you have legal custody of this child: [ ] Yes [ ] No

General Information

Date: ______________

Who is your Dentist? ______________________

Last visit date: ________ Dentist Phone #: ________

Whom may we thank for referring you? ______________

Emergency contact *not living with you:*

Name: ____________ Relationship: ____________

Home Phone: __________ Work Phone: __________

Adult Patient or Parent's Information

Patient or Mother's Name: ______________________

Date of Birth: __________ SS#: ______________

Address: ______________________

____
City State Zip

Home Phone: __________ Work: ______________

Father's Name: ______________________

Date of Birth: __________ SS#: ______________

Address: ______________________

____
City State Zip

Home Phone: __________ Work: ______________

Insurance Information

Subscriber's Name: ______________________

Date of Birth: __________ SS#: ______________

Relationship to patient: ______________________

Insurance Company: ______________________

ID#: ______________ Group# ______________

Hippa

As of April 14, 2003, Federal and State Law requires us to maintain the privacy of your health information.

SIGNATURE:

I attest that the information on this form is correct.

Signature: ______________________

Date: ______________________

Assignment And Release

I, the undersigned certify that I (or my dependent) have coverage with the obtained insurance information, and assign directly Dr. John H. Jones, III, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

Relationship: ______________ Date: ________

Dental History

Bad breath	Yes	No
Bleeding gums	Yes	No
Blisters on lips or mouths	Yes	No
Burning sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, Pipe or Cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Fingernail biting	Yes	No
Food collection between the teeth	Yes	No
Foreign objects	Yes	No
Grinding teeth	Yes	No
Gums swollen or tender	Yes	No
Jaw Pain or tiredness	Yes	No
Lip or cheek biting	Yes	No
Loose teeth or broken fillings	Yes	No
Mouth breathing	Yes	No
Mouth pain, brushing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to sweets	Yes	No
Sensitivity when biting	Yes	No
Sores or growth in your mouth	Yes	No

How often do you floss? ___________________________

How often do you brush? ___________________________

Allergies

[ ] No Known Allergies

[ ] Allergies
[ ] Barbiturates (Sleeping Pills)
[ ] Codeine
[ ] Iodine
[ ] Latex ________________________
[ ] Local Anesthetic
[ ] Penicillin
[ ] Sulfa
[ ] Other ____

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

____

Pharmacy Name: ____

Pharmacy Phone: ____

Women

Are you pregnant?	Yes	No

If yes, due date: ____

Taking birth control pills?	Yes	No
Are you nursing?	Yes	No

Health History

Physician's name: _________________________________

Have you had any of the following:

AIDS/HIV	Yes	No
Anemia	Yes	No
Arthritis, Rheumatism	Yes	No
Artificial Heart Valves	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
Bleeding abnormally, with Extractions or surgery	Yes	No
Blood Disease	Yes	No
Cancer	Yes	No
Chemical Dependency	Yes	No
Chemotherapy	Yes	No
Circulatory Problems	Yes	No
Congenital Heart Lesions	Yes	No
Cortisone Treatments	Yes	No
Cough, persistent or bloody	Yes	No
Diabetes	Yes	No
Emphysema	Yes	No
Epilepsy	Yes	No
Fainting or dizziness	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Heart Murmur	Yes	No
Heart Problems	Yes	No
Hepatitis Type ____	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
Jaundice	Yes	No
Jaw Pain	Yes	No
Kidney Disease	Yes	No
Low Blood Pressure	Yes	No
Mitral Valve Problems	Yes	No
Nervous Problems	Yes	No
Pacemaker	Yes	No
Psychiatric Care	Yes	No
Radiation Treatment	Yes	No
Respiratory Disease	Yes	No
Rheumatic Fever	Yes	No
Shortness of Breath	Yes	No
Sinus Trouble	Yes	No
Skin Rash	Yes	No
Special Diet	Yes	No
Stroke	Yes	No
Swollen Neck Gland	Yes	No
Swollen Feet or Ankles	Yes	No
Thyroid Problem	Yes	No
Tonsillitis	Yes	No
Tuberculosis	Yes	No
Tumor or growth on head or neck	Yes	No
Ulcer	Yes	No
Weight Loss Unexplained	Yes	No