

WELCOME TO DR. LAMONT B. JACOBS ORTHODONTICS

Brace yourself for a new smile

Insurance Company Name							
Address	Patient's Name	First	MI La	st		Likes to be called	
Address	Birth Date		Age	M / F (plea	ase circle)		
Street			_	· ·	,		
Home Phone# Cell Phone# Cell Carrier Cell Carrier (For appointment confirmation teats)	Street		City	Sta	ate	Zip	
Physician Dentist Last Dental Exam Date Have we seen other members of your family? If so, Name Who can we thank for referring you? Employer	Email Address			Social Secu	ırity#		
Physician Dentist Last Dental Exam Date Have we seen other members of your family? If so, Name Who can we thank for referring you? Employer	Home Phone#		Cell Phone#	Cell Carrier			
Have we seen other members of your family? If so, Name Who can we thank for referring you? Employer If patient is a minor: Parent/Guardian Name Parent/Guardian Address (if different) Home Phone# Cell Phone# Cell Phone# Cell Carrier School Hobbies/Interest PERSON RESPONSIBLE FOR ACCOUNT SELF Name Date of Birth Relationship Relationship Address (if different than patient) Email Address Street City State Zip Phone# Date of Birth Responsible PARTY Name Date of Birth Responsible PARTY ADDITIONAL RESPONSIBLE PARTY Name Date of Birth Responsible PARTY Name Date of Birth Relationship Relationship ADDITIONAL RESPONSIBLE PARTY Name Date of Birth Relationship ADDITIONAL RESPONSIBLE PARTY Name Date of Birth Relationship Address Email							
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Address Street City State Zip	Insurance Company N	ame					
	Address						
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	PATI	ENT'S MEDICAL HEA	LTH HISTORY			
1. Present health: □ E	excellent	☐ Fair ☐ Poor				
2. Has present health CH	IANGED in the last year	☐Yes ☐No If yes, please	e explain:			
3. Hospitalized for illness or surgery		☐Yes ☐No If yes, please	e explain:			
4. Treatment by a doctor to last two years	for any condition in the	□Yes □No If yes, please	e explain:			
5. ALLERGIC to any drug	gs, Latex or other substances	☐Yes ☐No If yes, please	e explain:			
6. Experienced BLEEDIN	IG that was difficult to stop?	☐Yes ☐No If yes, please	e explain:			
7. Has anyone in your far	mily ever had DIABETES?	☐Yes ☐No If yes, please	e explain:			
8. Required to restrict his	/her work ACTIVITY?	☐Yes ☐No If yes, pleas	e explain:			
9. DIET restricted or spec	cially prescribed ?	□Yes □No If yes, please explain:				
10. Is patient taking any N (even asprin, vitamins,	MEDICATIONS? hormones or antacids)?	□Yes □No				
If so, please list all drugs	with dosages.:					
	A	9 12				
	DO YOU HAVE,	OR HAVE YOU HAD A	NY OF THE FOLLOWING?			
☐ Heart Trouble	☐ Diabetes	☐ Stroke	☐ Sinus Trouble	IF FEMALE		
☐ Heart Murmur	☐ Kidney Disease	☐ Arthritis	☐ Hay Fever	□ Pregnant		
☐ Heart Surgery	☐ Liver Disease	☐ Anemia / Blood Disease	☐ Artificial Joints	■ Menopause		
☐ High Blood Pressure	☐ Asthma	☐ Hepatitus	☐ Immune System Problems	Oral Contraceptive		
☐ Low Blood Pressure		· ·				
	☐ Lung Disease	☐ Frequent Headaches	☐ Psychiatric Care			
☐ Hives / Rash	□ Epilepsy	☐ Heavy Smoker	☐ Tumors / Growths			
☐ Jaundice	☐ Fainting	☐ Any recent unintentional Weight Changes				
Have you ever had an	y serious illness not listed	above? □Yes □No	If yes, Explain			
-						
		DATIENTIC DENITAL I	HCTORY			
		PATIENT'S DENTAL H	HISTORY			
HAS PATIENT EVER	HAD THE FOLLOWING T	REATMENT OR ARE YOU	AWARE OF ANY OF THE FOL	LOWING CONDITIONS:		
☐ Mouthguard or sp	olint (plastic device between	en the teeth)	enching or grinding the teeth			
☐ Treatment or surg	gery to change the bite	□ Nu	umbness or tingling in the mout	h or face		
☐ Sores, lumps or in	rritated areas in the mouth	n 🗖 Mo	☐ Mouth breathing or snoring			
☐ Food catching or	collecting between the te	eth 🔲 Is	patient frightened or anxious ab	oout orthodontic treatmen		
☐ Have you had an	unpleasant experience a	t a dental office? Explai	n:			
☐ Would you chang	e anything about your tee	eth or smile? If so tell us _				
	ghtening of your teeth)			Unhappy with result		
☐ Extractions	Date: Reas	on:	a new smile			
☐ Periodontal treatn	nent (gum treatment)	Date: Treat	ment Description:			
☐ Clicking, popping	or grating noise in the jav	when chewing	Is it bothersome?			
•	•	_				
Over the past five	e years, how often have ye	ou been seen for teeth cle	aning?			
Signature			Date			