WELCOME TO DR. LAMONT B. JACOBS ORTHODONTICS

Brace yourself for a new smile

Patient's Name _____ _____
First MI Last Likes to be called

Birth Date _____ Age _____ M / F (please circle)

Address _____
Street City State Zip

Email Address _____ Social Security# _____

Home Phone# _____ Cell Phone# _____ Cell Carrier _____
(For appointment confirmation texts)

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 _____

If patient is a minor: Parent/Guardian Name _____

Parent/Guardian Address (if different) _____

Home Phone# _____ Cell Phone# _____ Cell Carrier _____

School _____ Hobbies/Interest _____

PERSON RESPONSIBLE FOR ACCOUNT ☐ SELF

Name _____ Date of Birth _____ Relationship _____

Address _____
(If different than patient)

Email Address _____ Social Security# _____

Home Phone# _____ Cell Phone# _____ Cell Carrier _____
(For appointment confirmation texts)

Employer Name _____

Dental Insurance?

Insurance Company Name _____

Address _____
Street City State Zip

Phone# _____ ID# or SS# _____ Group# _____

ADDITIONAL RESPONSIBLE PARTY

Name _____ Date of Birth _____ Relationship _____

Address _____
(If different than patient)

Email Address _____ Social Security# _____

Home Phone# _____ Cell Phone# _____ Cell Carrier _____
(For appointment confirmation texts)

Employer Name _____

Dental Insurance?

Insurance Company Name _____

Address _____
Street City State Zip

Phone# _____ ID# or SS# _____ Group# _____

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PATIENT'S MEDICAL HEALTH HISTORY

1. Present health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
2. Has present health CHANGED in the last year ❑Yes ❑No If yes, please explain: _____
3. Hospitalized for illness or surgery ❑Yes ❑No If yes, please explain: _____
4. Treatment by a doctor for any condition in the last two years ❑Yes ❑No If yes, please explain: _____
5. ALLERGIC to any drugs, Latex or other substances ❑Yes ❑No If yes, please explain: _____
6. Experienced BLEEDING that was difficult to stop? ❑Yes ❑No If yes, please explain: _____
7. Has anyone in your family ever had DIABETES? ❑Yes ❑No If yes, please explain: _____
8. Required to restrict his/her work ACTIVITY? ❑Yes ❑No If yes, please explain: _____
9. DIET restricted or specially prescribed ? ❑Yes ❑No If yes, please explain: _____
10. Is patient taking any MEDICATIONS? (even asprin, vitamins, hormones or antacids)? ❑Yes ❑No

If so, please list all drugs with dosages.: _____

_____

DO YOU HAVE, OR HAVE YOU HAD ANY 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 any serious illness not listed above? ❑Yes ❑No If yes, Explain _____

_____

PATIENT'S DENTAL HISTORY

HAS PATIENT EVER HAD THE FOLLOWING TREATMENT OR ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

- ❑ Mouthguard or splint (plastic device between the teeth)
- ❑ Treatment or surgery to change the bite
- ❑ Sores, lumps or irritated areas in the mouth
- ❑ Food catching or collecting between the teeth
- ❑ Clenching or grinding the teeth
- ❑ Numbness or tingling in the mouth or face
- ❑ Mouth breathing or snoring
- ❑ Is patient frightened or anxious about orthodontic treatment
- ❑ Have you had an unpleasant experience at a dental office? Explain: _____
- ❑ Would you change anything about your teeth or smile? If so tell us _____
- ❑ Orthodontic (straightening of your teeth) . . . . . ❑ As a child ❑ As an adult ❑ Happy with result ❑ Unhappy with result
- ❑ Extractions . . . . . Date: _____ Reason: _____
- ❑ Periodontal treatment (gum treatment) . . . . . Date: _____ Treatment Description: _____
- ❑ Clicking, popping or grating noise in the jaw when chewing . . . . . Is it bothersome? _____
- ❑ Finger or thumb sucking . . . . . To what age? _____
- ❑ Over the past five years, how often have you been seen for teeth cleaning? _____

Signature _____ Date _____

(Guardian if minor)