# JONES FAMILY DENTISTRY
## *SCOTT L. JONES, D.D.S*

### PATIENT INFORMATION AND MEDICAL HISTORY UPDATE

DATE: _____

NAME: _____ DATE OF BIRTH_____

ADDRESS: _____ EMAIL:_____

CITY: _____ STATE: _____ ZIP: _____

HM PHONE: _____ WK PHONE: _____ SS: _____

MOBILE: _____ EMPLOYER: _____ DL# _____

## MEDICAL HISTORY

PLEASE CIRCLE THOSE APPLICABLE.

| | | | |
|---|---|---|---|
| ABNORMAL BLEEDING | HEART MURMUR | DIABETES | HEPATITIS |
| LIVER PROBLEMS | HEART ATTACK | TUBERCULOSIS | ANEMIA |
| LUNG PROBLEMS | HEMOPHILIA | STD/HIV/AIDS | ASTHMA |
| RHEUMATIC FEVER | KIDNEY PROBLEM | ARTIFICIAL DEVICES | CANCER |
| HIGH/LOW BLOOD PRESSURE | | MITRO - VALVE PROLAPSE | |

PREGNANCY_____ MO

LIST ANY OTHER MEDICAL CONCERNS: _____

LIST ALL MEDICATIONS PATIENT IS TAKING: _____

_____

LIST ALL MEDICATIONS PATIENT IS ALLERGIC TO: _____

_____

PHYSICIAN'S NAME: _____ PHONE: _____

## DENTAL UPDATE

WHY HAVE YOU COME TO THE DENTIST TODAY? _____

DO YOUR GUMS EVER BLEED? YES OR NO

WOULD YOU LIKE WHITER TEETH? YES OR NO

HAVE YOU EVER HAD BOTOX OR DERMAL FILLERS? YES OR NO

**INSURANCE UPDATE**

DO YOU HAVE DENTAL INSURANCE? YES OR NO

INSURANCE COMPANY: _____ INS. PHONE: _____ INS. ADDRESS: _____

NAME OF POLICY HOLDER: _____ SS: _____ DOB: _____

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____