JEFFREY F. WARD, D.D.S.

PATIENT'S INFORMATION

Patient's Name: Last_____First_____Middle_____Social Security # _____
Birthdate:_____Age:_____Sex: M F Marital Status:_____Home Phone (___) _____
Email: _____Cell (___)_____
Address-Street:_____City:_____State:_____Zip: _____
How long at this address?_____ Own:_____Rent:_____
Previous Address (if less than 3 years) Street:_____City:_____State:_____Zip: _____
Employer:_____Position:_____No. Years employed: _____
Employer's Address:_____Work Phone (___)_____
Have you ever filed for bankruptcy?_____If patient is a minor, give parent or guardian's name: _____
Whom may we thank for referring you to our office?_____
Method of payment: Cash_____Credit Card: Visa / Master Card / Amex / Care Credit

SPOUSE'S INFORMATION

Spouse's Name: Last_____First_____Middle_____Social Security #_____
Birthdate:_____Employer:_____#_____Employer's Address:_____

RESPONSIBLE PARTY INFORMATION

Name: Last_____First_____Middle_____Marital Status: _____
Address-Street:_____City:_____State:_____Zip: _____
Social Security #_____Birthdate:_____Relationship to patient: _____
Employer:_____Position:_____No. Years employed: _____
Employer's Address:_____Work Phone (___)_____

INSURANCE INFORMATION

Name of Insured:_____Relationship to patient:_____Birthdate: _____
Member #_____Name of Employer:_____Work Phone (___) _____
Employer's Address: _____
Insurance Company Name:_____Group #_____Phone (___)_____
Insurance Company Address: _____State:_____Zip:_____
Do you have dual coverage? If yes, complete below
Name of Insured:_____Relationship to patient:_____Birthdate: _____
Member #_____Name of Employer:_____Work Phone (___) _____
Employer's Address: _____
Insurance Company Name:_____Group #_____Phone (___)_____
Insurance Company Address: _____State:_____Zip:_____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____
Address: _____Phone (___) _____
Physician's Name:_____Phone (___) _____

CONSENT

The undersigned hereby authorizes Dr. Jeffrey F. Ward to take x-rays, study models, photographs or any other diagnostic aids de emed appropriate by him to make a thorough diagnosis of the patients dental needs. I also authorize Dr. Ward to perform any and all forms of treatment, medication and therapy that may be indicated, and further authorize and consent that Dr. Ward choose and employ such assistants as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. There are certain risks w ith other dental procedures, which will be rendered to me, and I have had the opportunity to ask any questions. I understand that dentistry is not an exact science and that the results of treatment and outcome cannot be assured.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:_____DATE:_____

DENTAL HISTORY

Reason for today's visit_____(Fee for emergency treatment is payable at time of appointment)
Are you currently in pain? YES NO
Do you need to premedicate before dental treatment? YES NO
Have you experienced problems associated with any previous dental work? YES NO
Do you have or have you ever experienced pain in your jaw joint (TMJ/TMD)? YES NO
Your current dental health is: Good Fair Poor Do you floss daily? YES NO Brush daily? YES NO
Type of bristles on your toothbrush? Soft Medium Hard
Do you use anything in addition to your brush or floss? If yes, what_____
Do your gums bleed? YES NO Does food catch between your teeth._____
Have you ever had periodontal disease? YES NO
Do any of your teeth feel loose? YES NO
Are your teeth sensitive to: Hot Cold Sweets or anything else? _____
Previous dentist_____ Date of last dental visit _____
Are you dissatisfied with your teeth and their appearance?_____
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? _____
Have you ever had any teeth removed? _____
How long have these teeth been missing? _____
Do you feel you will eventually wear artificial dentures?_____
Do you have any fears? _____
Are you deeply concerned about the finances required to return your teeth to excellent dental health? _____

MEDICAL HISTORY

Have you been a patient in a hospital during the past two years? ---------- YES NO
Have you been under the care of a medical doctor during the past two years?---------- YES NO
Are you now taking any medication, drugs or pills? ---------- YES NO
If yes, please list _____

Are you allergic to any medications or substances?---------- YES NO
Circle any of the following, which you have had or have at present:

Heart Failure	Heart Murmur	Artificial Heart Valve	Anemia
Emphysema	Hay Fever	Thyroid Disease	Rheumatism
A.I.D.S.	Yellow Jaundice	Bruise Easily	Fainting or Dizzy Spells
Heart Disease or Attack	Rheumatic Fever	Heart Pacemaker	Stroke
Cough	Sinus Trouble	X-ray/Cobalt Treatment	Cortisone Medicine
Hepatitis A (infectious)	Blood Transfusion	Cold Sores	Nervousness
Angina Pectoris	Allergies/Hives	Heart surgery	Kidney Trouble
Tuberculosis (TB)	Congenital Heart Lesions	Chemotherapy	Glaucoma
Hepatitis B	Drug Addiction	(Cancer/Leukemia)	Psychiatric Treatment
High Blood Pressure	Scarlet Fever	Fever Blisters	Ulcers
Asthma	Diabetes	Artificial Joints (Hip, Knee)	Pain in Jaw Joints
Liver Disease	Hemophilia	Arthritis	Sickle Cell Disease
		Epilepsy or Seizures	COPD

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?
or shortness of breath, or because you are very tired? ---------- YES NO
Do your ankles swell during the day?---------- YES NO
Do you ever wake up from sleep short of breath? ---------- YES NO
Has your medical doctor ever said you have a cancer or tumor? ---------- YES NO
Do you smoke? Yes_____ No_____
Do you have any disease, condition, or problem not listed? ---------- YES NO

FOR WOMEN ONLY:
Are you pregnant? Yes No If yes, what month?_____
Are you taking birth control pills?---------- YES NO

I certify that the above information is accurate_____ ____/____/____
Signature **Date**