CARL JENKINS, DDS
Cosmetic, Implant, & Family Dentistry

570-538-5005
315 Main Street, Watsontown, PA

Welcome! Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please call us. We will be happy to help!

Patient Information

Name _____ **SS#** _____ **Date** _____

Sex ◯ m ◯ f **Birthdate** _____ **Home Phone** _____ **Cell Phone** _____

Address _____
Street City State Zip

Email _____

Do you prefer to receive calls at your: ◯ Home ◯ Work ◯ Cell Phone

Check Appropriate Circle: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

If Student, Name of School/College _____ _____
City State
◯ Full Time ◯ Part Time

Patient or Parent/Guardian's Employer _____ **Work Phone** _____

Business Address _____
Street City State Zip

Spouse or Parent/Guardian's Name _____ **Work Phone** _____

Employer _____

Whom may we thank for Referring You? _____

Person to Contact in Case of Emergency _____ **Phone** _____

Responsible Party

Name of Person Responsible for this Account _____ **Relationship to Patient** _____

Address _____ **Home Phone** _____

Email _____ **BIrthdate** _____ **Cell Phone** _____

Employer _____ **Work Phone** _____ **SS#** _____

Is this person currently a patient in our office? ◯ Yes ◯ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment due in full at each appointment.

◯ Cash ◯ Personal Check ◯ Credit Card ◯ VISA ◯ MasterCard ◯ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ **Relationship to Patient** _____

Insured's Address if different from patient's _____

Birthdate _____ **SS#** _____

Name of Employer _____ **Work Phone** _____

Address of Employer _____

Insurance Company _____ **Group #** _____ **Policy/ID #** _____

Insurance Co. Address _____ **City** _____ **State** _____ **ZIP** _____

How much is your deductible? _____ **How much have you used?** _____ **Max Annual Benefit** _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ◯ Yes ◯ No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured _____ **Relationship To Patient** _____

Insured's Address if different from patient's _____

Birthdate _____ **SS#** _____

Name of Employer _____ **Work Phone** _____

Address of Employer _____

Insurance Company _____ **Group #** _____ **Policy/ID #** _____

Insurance Co. Address _____ **City** _____ **State** _____ **ZIP** _____

How much is your deductible? _____ **How much have you used?** _____ **Max Annual Benefit** _____

Please complete both sides.

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? ◯ Yes ◯ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ◯ Yes ◯ No

If yes, please explain _____

3. Are you taking any medication(s) including non-prescription medicine? ◯ Yes ◯ No

If yes, what medication(s) are you taking?

4. Have you ever taken Fen-Phen/Redux? ◯ Yes ◯ No
5. Do you use tobacco? ◯ Yes ◯ No
6. Do you use controlled substances? ◯ Yes ◯ No
7. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ◯ Yes ◯ No

8. Do have or have you had any of the following?

AIDS or HIV Infection	◯ Y ◯ N	Heart Murmur	◯ Y ◯ N
Anemia	◯ Y ◯ N	Heart Trouble	◯ Y ◯ N
Angina	◯ Y ◯ N	Hepatitis/Jaundice	◯ Y ◯ N
Arthritis	◯ Y ◯ N	High Blood Pressure	◯ Y ◯ N
Asthma	◯ Y ◯ N	Joint Replacement or Implant	◯ Y ◯ N
Back Problems	◯ Y ◯ N	Kidney Diseases	◯ Y ◯ N
Blood Disease	◯ Y ◯ N	Leukemia	◯ Y ◯ N
Blood Transfusions (within last 5 yrs.)	◯ Y ◯ N	Liver Disease	◯ Y ◯ N
Cancer	◯ Y ◯ N	Low Blood Pressure	◯ Y ◯ N
Cardiac Pacemaker	◯ Y ◯ N	Mitral Valve Prolapse	◯ Y ◯ N
Chemotherapy	◯ Y ◯ N	Radiation Therapy	◯ Y ◯ N
Chest Pains	◯ Y ◯ N	Recent Weight Loss	◯ Y ◯ N
Circulatory Problems	◯ Y ◯ N	Respiratory Problems	◯ Y ◯ N
Cortisone Treatment	◯ Y ◯ N	Rheumatic Fever	◯ Y ◯ N
Diabetes	◯ Y ◯ N	Scarlet Fever	◯ Y ◯ N
Easily Winded	◯ Y ◯ N	Sexually Transmitted Disease	◯ Y ◯ N
Emphysema	◯ Y ◯ N	Skin Rash	◯ Y ◯ N
Epilepsy/Convulsions	◯ Y ◯ N	Stomach Troubles/Ulcers	◯ Y ◯ N
Fainting/Seizures	◯ Y ◯ N	Stroke	◯ Y ◯ N
Frequently Tired	◯ Y ◯ N	Swollen Ankles	◯ Y ◯ N
Glaucoma	◯ Y ◯ N	Tonsillitis	◯ Y ◯ N
Hay Fever/Allergies	◯ Y ◯ N	Tuberculosis	◯ Y ◯ N
Heart Attack	◯ Y ◯ N	Thyroid Problem	◯ Y ◯ N
Heart Disease	◯ Y ◯ N	Other _____	◯ Y ◯ N

9. Are you allergic to or have you had any reactions to the following?

- **Local Anesthetics** (e.g. Novocain) ◯ Yes ◯ No
- **Penicillin or any other Antibiotics** ◯ Yes ◯ No
- **Sulfa Drugs** ◯ Yes ◯ No
- **Barbiturates** ◯ Yes ◯ No
- **Sedatives** ◯ Yes ◯ No
- **Iodine** ◯ Yes ◯ No
- **Aspirin** ◯ Yes ◯ No
- **Any Metals** (e.g. nickel, mercury, etc.) ◯ Yes ◯ No
- **Latex Rubber** ◯ Yes ◯ No

List any other allergies you may have including food allergies

_____

10. Are you taking any of the following Bisphosphanates?

Actonel	◯ Yes	◯ No	Aredia	◯ Yes	◯ No
Boniva	◯ Yes	◯ No	Didronel	◯ Yes	◯ No
Fosamax	◯ Yes	◯ No	Skelid	◯ Yes	◯ No
Zometa	◯ Yes	◯ No			

11. Women Only:
- Are you pregnant or think you may be pregnant? ◯ Yes ◯ No
- Are you nursing? ◯ Yes ◯ No
- Are you taking oral contraceptives? ◯ Yes ◯ No

Patient Dental History

Name of previous dentist and location _____ Date of last exam _____

1. Do your gums bleed while brushing or flossing? ◯ Yes ◯ No
2. Are your teeth sensitive to hot or cold liquids/foods? ◯ Yes ◯ No
3. Are your teeth sensitive to sweet or sour liquids/foods ◯ Yes ◯ No
4. Are your teeth sensitive when biting? ◯ Yes ◯ No
5. Do you have dry mouth? ◯ Yes ◯ No
6. Do you have bad breath? ◯ Yes ◯ No
7. Do you have food collection between your teeth? ◯ Yes ◯ No
8. Do you have loose teeth or broken fillings? ◯ Yes ◯ No
9. Do you feel pain to any of your teeth? ◯ Yes ◯ No
10. Have you ever experienced any of the following in your jaw?
    - Clicking ◯ Yes ◯ No
    - Pain (joint, ear, side of face) ◯ Yes ◯ No
    - Difficulty in opening or closing ◯ Yes ◯ No
    - Difficulty in chewing ◯ Yes ◯ No
11. Do you have any sores or lumps in or near your mouth? ◯ Yes ◯ No
12. Have you had any head, neck or jaw injuries? ◯ Yes ◯ No
13. Do you have frequent headaches? ◯ Yes ◯ No
14. Do you clench or grind your teeth? ◯ Yes ◯ No
15. Do you bite your lips or cheeks frequently? ◯ Yes ◯ No
16. Have you had any periodontal treatment in the past? ◯ Yes ◯ No
17. Have you ever had any difficult extractions in the past ◯ Yes ◯ No
18. Have you ever had any prolonged bleeding following extractions? ◯ Yes ◯ No
19. Have you had any orthodontic treatment? ◯ Yes ◯ No
20. Do you wear dentures or partials? ◯ Yes ◯ No
    If yes, date of placement _____
21. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ◯ Yes ◯ No
22. Do you like your smile? ◯ Yes ◯ No

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including clinical photos and x-rays for educational purposes, the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment, with my informed consent.

_____

Signature of patient (or parent/guardian if minor) Date