Dr. John J. Dubos, DDS, Inc.
3425 Grant Avenue
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WELCOME!

ABOUT YOU:

Today's Date: ________________

E-Mail Address: __________________________

Name: __________________________________

Last First MI

I Prefer to be Called: ______________________

□ Male □ Female Birthdate: ___/___/___

SS# ____-____-____ Age: _____

Home Address: ___________________________

____

□ Single □ Married □ Divorced □ Widowed □ Separated

Home # (___) ________ Cell # (___) ________

Work # (___) _________ Ext. _____

Employer: _______________________________

Employer Address: _________________________

____

Occupation: _____________________________

Referred by: _____________________________

Other family seen here: ____________________

____

Previous/Present Dentist: ___________________

Last Visit Date: ___________________________

SPOUSE INFORMATION:

His/Her Name: ___________________________

Cell # (___) _____________ Birthdate __/__/__

SS# ____-____-____ Age: _____

Employer: _______________________________

Work # (___) _________ Ext. _____

ACCOUNT RESPONSIBILITY:

Person Responsible for Account: ____________

Relation: ________________________________

Billing Address: ___________________________

____

INSURANCE COVERAGE:

Primary

Dental Coverage □ Yes □ No

Company Name: __________________________

Company Address: ________________________

____

Company Phone: (___) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: __________________________

Relation: __________ Insured's ID #: ________

Secondary

Dental Coverage □ Yes □ No

Company Name: __________________________

Company Address: ________________________

____

Company Phone: (___) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: __________________________

Relation: __________ Insured's ID #: ________

EMERGENCY CONTACT:

Name: ________________ Relation: __________

Home # (___) ________ Cell # (___) _________

Work # (___) _________ Ext. _____

MEDICAL HISTORY:

Do you have a personal physician? □ Yes □ No

Physician's Name: ________________________

Phone #: (___) _______ Last Visit: ___________

Are you currently under their care? □ Yes □ No

Please Explain: ___________________________

____

____

____

MEDICAL HISTORY:

Your current physical health is: □ Good □ Fair □ Poor

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Epilepsy
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+ or AIDS
Y N Recent Hospitalization
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Sickle Cell Disease/Traits

Please list any other serious medical condition(s) that you have ever had: ____________________
____
____

Are you taking any prescription/over-the-counter or herbal supplement drugs: □ Yes □ No
Please list each one: _______________________
____
____
____
____
____

Have you ever taken Fosamax or any other bisphosphonates? □ Yes □ No

For Women: Are you taking a prescribed method of birth control? □ Yes □ No
Are you pregnant? □ Yes □ No Week # ______
Are you nursing? □ Yes □ No

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetic
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Sulfa Drugs
Y N Tetracycline

Please list any other drugs/materials you are allergic to: ________________________________
____
____

DENTAL HISTORY:

Why have you come to the dentist today?
____
____

Do you require antibiotics prior to dental treatment? □ Yes □ No
Are you currently in pain? □ Yes □ No
Do your gums ever bleed? □ Yes □ No
Have you ever had a serious problem associated with any previous dental visit? □ Yes □ No
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ)? □ Yes □ No
Your current dental health is: □ Good □ Fair □ Poor
Do you like your smile? □ Yes □ No
Would you like whiter teeth? □ Yes □ No
Would you like fresher breath? □ Yes □ No
How many times a day do you brush? ________
How many times a week do you floss? ________
Type of bristles? □ Soft □ Medium □ Hard
Do you smoke, use smokeless tobacco or tobacco in any other form? □ Yes □ No

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 services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance may not cover.

____
Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.