Please fill out information sheets (front & back), including all insurance information. An 800 # to verify benefits would be appreciated. Return them to our office in the enclosed self-addressed envelope as soon as possible. Thanks!

# JODY S. HARRISON, D.D.S.

## PATIENT INFORMATION RECORD

Welcome to our office. Please answer all questions. This information is confidential and will help us serve you better. If at any time you have any questions regarding your treatment, your appointments, or fees, please ask.

NAME________________________________________ DATE OF BIRTH__________
NAME YOU WISH TO BE CALLED________________________ MARITAL STATUS________
ADDRESS________________________________________________________
CITY__________________________ STATE______________ ZIP CODE__________
MAILING ADDRESS (IF DIFFERENT)_________________________________________
SOCIAL SECURITY #____________________ DRIVER LICENSE #________________
HOME PHONE________________________ CELL #__________________________
E-Mail Address:______________________________________________________

EMPLOYER_______________________________________________________
ADDRESS________________________________________________________
OCCUPATION___________________________ WORK PHONE #__________ Ext.______

SPOUSE_____________________________ EMPLOYER______________________
BUSINESS ADDRESS_____________________________________________________
PREFERRED PHONE #____________________________________________________

PERSON RESPONSIBLE FOR PAYMENT_________________________________________

IF PATIENT IS A MINOR, WHO HAS CUSTODY?__________________________________
IF MINOR PLEASE LIST PARENTS OR GUARDIAN INFORMATION ABOVE RE:
EMPLOYER_______________________________________________________

TO WHOM MAY WE SPEAK WITH CONCERNING YOUR PERSONAL HEALTH INFORMATION:
_______________________________________________________________

EMERGENCY CONTACT OTHER THAN SPOUSE:____________________________________
HOME PHONE:____________________ CELL #_________________________________
ADDRESS________________________ CITY__________ STATE ______ ZIP________
RELATIONSHIP TO YOU__________________________________________________

FAMILY PHYSICIAN_________________________ DATE OF LAST MEDICAL EXAM______
GENERAL DENTIST__________________________ DATE OF LAST DENTAL EXAM_______

WHO REFERRED YOU TO THIS OFFICE_______________________________________
REASON FOR REFERRAL__________________________________________________
IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

INSURED NAME_______________________________ INSURED BIRTH DATE_________
INSURED SOCIAL SECURITY #__________________ GROUP #____________________
EMPLOYER PROVIDING INSURANCE_________________________________________
INSURANCE COMPANY NAME______________________________________________
INSURANCE COMPANY ADDRESS___________________________________________

PLEASE LIST ANY OTHER DENTAL COVERAGE:
INSURED NAME_______________________________ INSURED BIRTH DATE_________
INSURED SOCIAL SECURITY #__________________ GROUP #____________________
EMPLOYER PROVIDING INSURANCE_________________________________________
INSURANCE COMPANY NAME______________________________________________
INSURANCE COMPANY ADDRESS___________________________________________

(CONTINUED ON BACK)

DENTAL HISTORY:
Have you had previous deep periodontal cleanings? _________When? _______________
Have you had periodontal or dental implant surgery?________When? _______________
Do your gums bleed?___________Do your teeth feel loose?________________________
Have you recently lost teeth because they were loose?______When?________________
Do you have gum recession that concerns you?_______Where?______________________
Have you ever had an extremely frightening experience with dentistry?__________
Explain: ____________________________________________________________________
Have you ever needed sedation to accomplish dental treatment?_________________

Pharmacy/Address:_____________________________________________________________

MEDICAL HISTORY:
Height:___________Weight:___________________ WOMEN:Are you pregnant? Y/N
List Medications or pills you currently take: ________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Recent hospitalization?_________For what?_____________________________________

Are you experiencing any of the following symptoms: fever, cough, muscle aches, sore throat, loss of taste, change in smell? _________________________________
Have you tested positive for COVID-19?_______ HIV/Other________________________

Smoke/vape/smokeless tobacco (circle one if yes) How many packs per day?_______

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: Please Mark Yes or No

Heart attack/MI_______date__________ Angina/chest pain_________________________
Heart valve replacement_____________ A Fib_______(anticoagulants?)_____________
Heart stent(s)______________________ Coronary artery bypass graft_____________
Bacterial endocarditis______________ Rheumatic fever___________________________
Pacemaker___________________________ High/low blood pressure (circle)__________
Congenital heart defect_____________ Stroke________date________________________
Other heart problem(list)___________ Bleeding problems/disorder_______________
Leukemia____________________________ Anemia______Blood transfusion_____________
Emphysema_________COPD_______________ Asthma______date of last attack__________
Tuberculosis______Chronic cough_____ Sinusitis________Seasonal allergies_______
Stomach ulcers______________________ Gastritis/colitis_________________________
Hepatitis________ A/B/C/D (circle) Liver disease___________Cirrhosis_________
Jaundice____________________________ Persistent diarrhea______________________
Artificial joint_____date___________ Arthritis______(Rheumatoid/Osteoarthritis)
Osteoporosis_____current medications(Fosamax,etc?)______________How long?______
Thyroid trouble_____________________ Diabetes______________Last HbA1c__________
Skin rash___________________________ Venereal disease__________________________
Kidney trouble______________________ Bladder trouble___________________________
Epilepsy/seizures____last attack____ Fainting/syncope/dizzy spells ____(circle)
History of cancer___________________ Chemotherapy______________________________
Family history of cancer____________ Drug/alcohol addiction____________________
Psychiatric treatment_______________ Organ transplant__________________________
Sleep Apnea_______ Do you use a CPAP_______Do you use an Oral Appliance_______

MEDICATION ALLERGIES Yes / No
Please list:__________________________________________________________________
______________________________________________________________________________

**SIGNATURE:**___________________________________________________________