



## Patient Information

Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ Birth Date \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_  
 Zip \_\_\_\_\_ Wk Phone \_\_\_\_\_  
 Sex: Male / Female Cell Phone \_\_\_\_\_  
 Single Married Widowed Divorced Separated Email Address \_\_\_\_\_  
 Whom may we thank for your referral \_\_\_\_\_

## Dental Insurance

Responsible party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birth date \_\_\_\_\_ SS# \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Group # \_\_\_\_\_  
 Employer Address \_\_\_\_\_

## In an Emergency (Not in your household)

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship \_\_\_\_\_ Alt Phone \_\_\_\_\_

## Assignment and Release

I, the Undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
 and assign benefits directly to Dr. Kathy Jacobsen. I am responsible for total charges whether or not paid by  
 insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits.  
 I authorize the use of this signature on all insurance submission.

\_\_\_\_\_  
 Responsible party signature

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Date

## Medications

List any medications that you are currently taking and the correlating diagnosis.

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

## Allergies

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Local Anesthetic             | <input type="checkbox"/> Codeine/ Valium /<br>sedatives | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Penicillin or<br>antibiotics | <input type="checkbox"/> Latex                          | <input type="checkbox"/> Asprin      |

## Health History

Physicians Name \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Reason \_\_\_\_\_ H  
ospitalizations \_\_\_\_\_

Check if you have had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV +                 | <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Sinus Trouble                      |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Skin Rash                          |
| <input type="checkbox"/> Arthritis, Rheumatism      | <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Artificial Heart<br>Valves | <input type="checkbox"/> Heart problems              | <input type="checkbox"/> Surgical Shunts                    |
| <input type="checkbox"/> Artificial Joints          | <input type="checkbox"/> Hepatitis Type _____        | <input type="checkbox"/> Swelling of the feet<br>or ankles  |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Herpes                      | <input type="checkbox"/> Swollen Neck Glands                |
| <input type="checkbox"/> Back Problems              | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Thyroid Problems                   |
| <input type="checkbox"/> Endocarditis               | <input type="checkbox"/> Immunosuppressed            | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Bleeding abnormally        | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Tumor or growth on<br>head or neck |
| <input type="checkbox"/> Bypass                     | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Ulcer                              |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Valvular Dysfunction               |
| <input type="checkbox"/> Chemical Dependency        | <input type="checkbox"/> Lupus                       |   |
| <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Mental Disorder             | <b>Women</b>  |
| <input type="checkbox"/> Congenital Heart<br>Defect | <input type="checkbox"/> Mitral Valve Prolapse       | <input type="checkbox"/> Pregnant: Due _____                |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Pacemaker/<br>Defibrillator | <input type="checkbox"/> Nursing                            |
| <input type="checkbox"/> Dialysis                   | <input type="checkbox"/> Psychiatric Care            | <input type="checkbox"/> Birth control                      |
| <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Radiation Treatment         |   |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Respiratory Disease         |   |
| <input type="checkbox"/> Fainting or dizziness      | <input type="checkbox"/> Rheumatic Fever             |   |
| <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Scarlet Fever               |   |
|   | <input type="checkbox"/> Shortness of breath         |   |