Brian L. James, D.D.S.
(319) 465-3533
630 S. Main St. • P.O. Box 416
Monticello, Iowa 52310

PATIENT INFORMATION (CONFIDENTIAL)

Patient # ____________________

Date ____________________

Name ____________________ Birth Date __________ Social Security # ____________

Home Address ____________________ Home Phone ____________

City ____________________ State __________ Zip __________ Cell Phone ____________

Sex: Male _____ Female _____ _____ Minor _____ Single _____ Married _____ Divorced _____ Widowed

Patient's or Parent's Employer ____________________ Work Phone ____________

Business Address ____________ City ____________ State _____ Zip _____

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

Who is financially responsible for this bill? ____________________

Whom may we thank for referring you? ____________________

Person to contact in case of an Emergency ____________________ Phone ____________

Family Physician ____________________ Phone ____________

INSURANCE INFORMATION:

Name of Insured ____________ Birth Date __________ Social Security # ____________

Name and Address of Employer ____________________ Phone ____________

Insurance Company Name and Address ____________________ Group # ____________

GENERAL INFORMATION:

What is the reason for today's visit? ____________________

Do you have any questions or concerns we can help you with today? ____________________

Do you love your smile? ____________ Is there anything you would like to change? ____________

Why did you leave your last dentist? ____________________

MEDICAL HISTORY AND INFORMATION:

Do you have or ever had?

- ☐ Arthritis
- ☐ AIDS
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart problem
- ☐ Hepatitis __A __B __C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other ____________

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain ____________________

Are you currently taking any medication? ☐ Yes ☐ No Please explain ____________________

Are you Allergic to? ☐ Aspirin ☐ Barbiturate ☐ Codeine ☐ Penicillin ☐ Other

Female Patients, are you Pregnant? ☐ Yes ☐ No If yes, due date ____________________

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

I understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered, regardless of insurance status. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes to the above information.

Signature ____________________ Date ____________

Parent or Guardian (if a minor) ____________________ Date ____________

E-mail: ____________________