NICHOLAS A. JAMISON II, DDS

About You

TODAY'S DATE:_____

PATIENT'S NAME:_____
LAST FIRST MIDDLE

MR ___MRS ___ MS ___ MALE____ FEMALE ____

SS#_____ BIRTH DATE:_____ AGE:_____

HOME ADDRESS:_____

_____

CHILD/STUDENT ___ SINGLE ___ MARRIED ____ DIVORCED ____

HOME#_____ CELL #_____

WORK# _____ EXT#_____ DL#_____

WHEN & WHERE ARE THE BEST TIMES TO REACH YOU?

_____

WHO MAY WE THANK FOR REFERRING YOU?

_____

OTHER FAMILY MEMBERS SEEN BY US:

_____

SPOUSE/PARENT/GUARDIAN INFORMATION

NAME _____

EMPLOYER _____

PHONE # _____ BIRTH DATE:_____

SSN_____

DENTAL INSURANCE (PRIMARY)

EMPLOYER _____

EMPLOYER'S ADDRESS _____

INSURANCE NAME _____

INSURANCE ADDRESS _____

GROUP # _____MEMBER ID_____

INSURED'S NAME_____

INSURED'S DOB _____INSURED'S SSN _____

DENTAL INSURANCE (SECONDARY)

EMPLOYER _____

EMPLOYER'S ADDRESS _____

INSURANCE NAME _____

INSURANCE ADDRESS _____

GROUP # _____MEMBER ID_____

INSURED'S NAME_____

INSURED'S DOB _____INSURED'S SSN _____

Medical Information

PREVIOUS DENTIST _____

DATE OF LAST VISIT _____ LAST XRAYS_____

PERSONAL PHYSICIAN _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Y N Heart Attack/Stroke	**Y N** Cancer/Chemotherapy
Y N Heart Murmur	**Y N** HIV / AIDS
Y N Rheumatic Fever	**Y N** Sinus Problems
Y N Mitral Valve Prolapse	**Y N** Fever Blisters
Y N Congenital Heart Defect	**Y N** Diabetes
Y N Artificial Valves/Bones/Joints	**Y N** Difficulty Breathing
Y N Shingles	**Y N** Asthma
Y N Kidney Problems	**Y N** Arthritis
Y N High/Low Blood Pressure	**Y N** Emphysema
Y N Herpes	**Y N** Glaucoma
Y N Hemophilia/Abnormal Bleeding	**Y N** Hepatitis
Y N Epilepsy/Seizures/Fainting	**Y N** Tuberculosis
Y N Severe/Frequent Headaches	**Y N** Drug/Alcohol Use
Y N Anemia/Radiation Treatment	**Y N** Ulcers/Colitis
Y N Thyroid Disorders	**Y N** Are you Pregnant

Y N Hospitalized for any reason
Please list reason(s):_____

_____

List any other serious medical condition(s) that you have/ had:

_____

_____

List any medications you are taking:_____

_____

Are you allergic to any of the following drugs?

Y N Penicillin	**Y N** Tetracycline
Y N Aspirin	**Y N** Dental Anesthetics
Y N Erythromycin	**Y N** Codeine
Y N Latex	**Y N** Clindamycin

Other allergies:_____

Y N Do you now or have your ever experienced pain in your jaw (TMJ/TMD)?

Y N Do your gums bleed? **Y N** Do you like your smile?

In case of an emergency contact:_____ Phone:_____ Relationship:_____

There is no finance charge when statements are paid promptly. The late payment charge is imposed on accounts 90 days past due with no payments made within 30 days. Late payment finance charge is 1.5% per month with a minimum charge of $1.00. The patient/responsible party of the dental bill agrees to pay all costs of collections including reasonable attorney fees.

SIGNATURE _____ DATE_____

INFORMED CONSENT AND PERMISSION TO TREAT

Before you give your permission for any dental treatment, the removal of teeth, impacted or erupted, and for the administration of anesthetics, you should understand there are certain associated risks.

The common risks are (but not limited to):

1. Drug reactions and side effects to anesthetics, analgesic gas, or medications used in dental treatments.
2. Damage to adjacent teeth and fillings.
3. Post-operative infection or post-operative bleeding that may require treatment.
4. Possibility of a small fragment of a root being left in the jaw, its removal would require additional, more traumatic surgery.
5. Delayed healing (dry socket) requiring frequent post-operative care.
6. Possible involvement of the sinus during removal of upper molars which may require additional treatment or surgical repair at a later date.
7. Possible involvement of the nerve within the jaw during the removal of lower teeth, or from an injection, resulting in temporary (but possibly permanent) tingling, or numbness of the lower lip, chin, or tongue.
8. In a root canal procedure, separated root canal instruments within the canals of the tooth which may cause the failure of a root canal procedure and loss of the tooth, or cause the need for further surgical procedures.
9. Aspiration or swallowing of foreign objects.
10. Bruising, hematomas, or vein inflammation at the site of injection which may require further treatment.
11. Post-operative bleeding, post-operative infection, possible fracture of the mandible during the removal of a tooth.
12. Soreness or dislocation of the jaw joint (TMJ), soreness of the jaw muscles after the mouth has been held open for extended periods of time during treatment, or from a “high” restoration, from the use of a snoring (sleep apnea) device, or from any device or procedure that alters the occlusion (bite).

I hereby acknowledge that I have completely read the foregoing; will have discussed any questions or concerns which I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I am aware that the practice of dentistry is not an exact science, and no guarantees can be provided. I grant authority to Nicholas A. Jamison II to administer any treatment, to administer any anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risks and possible consequences of the procedures, and do authorize to the above doctor to proceed.

Name (please print) _____

Signature _____Date_____

Witness _____Date_____