Jay M. Hodge, D.D.S.

Restorative, Esthetic and Implant
General Practice of Dentistry

Thank you for selecting our dental team.

To help us meet all your health care needs, please fill out the front and back of this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION **DATE**_____

Name_____ ❑ Married ❑ Single ❑ Child ❑ Male ❑ Female

Social Security Number/Patient ID_____ Birth date_____

Address _____ City _____ State____ Zip _____

Phone: *Home* _____ *Work* _____ *Cell* _____

Email _____ Preferred Method of Contact _____

Employer _____ F/T Student?_____ School _____

Employer Address_____ City _____ State___ Zip _____

Emergency Contact _____ Phone_____

How did you hear about us? _____

RESPONSIBLE PARTY *(if other than patient)*

Person responsible for this account_____ Relationship to Patient _____

Address *(if different from above)* _____

Phone: *Home* _____ *Work* _____ *Cell* _____

Name and address of employer_____

PRIMARY INSURANCE INFORMATION

Name of insured_____ Relationship to Patient _____

Social Security Number/Subscriber ID _____ Birth date_____

Employer _____ Work phone_____

Employer Address_____

Insurance Company _____ Group Number _____

Insurance Company Address_____ City _____ State____ Zip _____

How much is your deductible? _____ Annual Maximum_____ Remaining Amount _____

SECONDARY INSURANCE INFORMATION

Name of insured_____ Relationship to Patient _____

Social Security Number/Subscriber ID _____ Birth date_____

Employer _____ Work phone_____

Employer Address_____

Insurance Company _____ Group Number _____

Insurance Company Address_____ City _____ State____ Zip _____

How much is your deductible? _____ Annual Maximum_____ Remaining Amount _____

METHOD OF PAYMENT

The dental office will file all dental insurance claims, and accepts payment by cash, check or credit card.

I will pay by: ❑ cash ❑ check ❑ credit card

❑ I wish to discuss the Dental Office Financial Policy. ❑ I wish to discuss your third party finance options.

DENTAL HISTORY

What is the nature of today's visit? ❑ Exam ❑ Consultation ❑ Emergency _____

Date of last dental care _____ Date of last x-rays _____

Please check any of the following that apply to you:

❑ Bad breath ❑ Bleeding gums ❑ Clicking/popping of the jaw ❑ Trapping food between teeth
❑ Grinding teeth ❑ Loose or broken fillings ❑ Periodontal treatment ❑ Sensitivity to cold
❑ Sensitivity to sweets ❑ Sensitivity when biting ❑ Sores or growths in the mouth ❑ Sensitivity to heat

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? _____

Other information about your dental health or previous treatment? _____

MEDICAL HISTORY

Physician's Name _____ City _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? ❑ Yes ❑ No

If yes, describe _____

Are you currently under physician care? ❑ Yes ❑ No If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate date _____

Have you ever taken Fen-Phen/Redux? ❑ Yes ❑ No Have you ever taken osteoporosis medications? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Using birth control medication? ❑ Yes ❑ No

Check if you have had any of the following:

❑ AIDS/HIV positive ❑ Circulatory problems ❑ Herpes ❑ Respiratory disease
❑ Anaphylaxis ❑ Cortisone treatments ❑ Hepatitis ❑ Rheumatic/scarlet fever
❑ Anemia ❑ Cough, persistent ❑ High blood pressure ❑ Shingles
❑ Arthritis, rheumatism ❑ Diabetes ❑ Jaw pain ❑ Shortness of breath
❑ Artificial heart valve ❑ Epilepsy ❑ Kidney problem ❑ Skin rash
❑ Artificial joints ❑ Fainting ❑ Liver disease ❑ Surgical implant
❑ Asthma ❑ Food allergies ❑ Material allergies (wood, latex, metal, chemicals) ❑ Swelling of feet or ankles
❑ Atopic (allergy prone) ❑ Glaucoma ❑ Thyroid disease/malfunction
❑ Back problem ❑ Headaches ❑ Mitral valve prolapse ❑ Tobacco habit
❑ Blood disease ❑ Heart murmur ❑ Nervous problems ❑ Tonsillitis
❑ Cancer ❑ Heart problems *(describe)* ❑ Pacemaker/heart surgery ❑ Tuberculosis
❑ Chemical dependency _____ ❑ Rapid weight gain/loss ❑ Ulcer/Colitis
❑ Chemotherapy ❑ Hemophilia/abnormal bleeding ❑ Radiation treatment

Is patient currently taking any medications? If yes, list all: _____

_____

_____

_____

Does patient have any drug allergies? If yes, list all *(including local anesthetics, e.g. Novocaine)*: _____

_____

AUTHORIZATION

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health.

I authorize the benefit plan(s) listed on this form to pay to the dentist all insured benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all benefit submissions. I authorize the dentist to release any information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by a benefit plan. I consent to the use and disclosure of my protected health information to carry out health care operations, treatment and payment activities (HIPAA).

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient