



410 Ashton Place NE
 Cedar Rapids, Iowa 52402
 Ph. 319.377.6504

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

I prefer to be called: _____ Male Female

Birth date: _____ SSN: _____

Marital Status: _____

Home address: _____

Hm # _____ Cell # _____

Wk # _____ Pgr # _____

Email _____

How do you prefer to confirm your appointments?

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

Previous / Present Dentist: _____

Last Visit Date: ____/____/____ Ph# _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

ID # _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

ID # _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relation: _____

Wk # _____ Hm # _____

***A note for patients with dental insurance** – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.*

Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? Yes No

If yes, please list: _____

Do you use or smoke tobacco in any form? Yes No

Do you consume alcohol? Yes No

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No week# _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | | | |
|---|-----------------------|---|-------------------------|
| Y <input type="checkbox"/> N <input type="checkbox"/> | Abnormal Bleeding | Y <input type="checkbox"/> N <input type="checkbox"/> | HIV+/AIDS |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Alcohol/Drug Abuse | Y <input type="checkbox"/> N <input type="checkbox"/> | Hospitalized Any Reason |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Anemia | Y <input type="checkbox"/> N <input type="checkbox"/> | High Blood Pressure |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Arthritis | Y <input type="checkbox"/> N <input type="checkbox"/> | Liver Disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Asthma | Y <input type="checkbox"/> N <input type="checkbox"/> | Low Blood Pressure |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Cancer/Chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> | Mitral Valve Prolapse |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Diabetes | Y <input type="checkbox"/> N <input type="checkbox"/> | Nervous/Anxious |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Difficulty Breathing | Y <input type="checkbox"/> N <input type="checkbox"/> | Pacemaker |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Emphysema | Y <input type="checkbox"/> N <input type="checkbox"/> | Psychiatric Problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Epilepsy | Y <input type="checkbox"/> N <input type="checkbox"/> | Radiation Treatment |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Fainting Spells | Y <input type="checkbox"/> N <input type="checkbox"/> | Rheumatic/Scarlet Fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Frequent Headaches | Y <input type="checkbox"/> N <input type="checkbox"/> | Seizures |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Glaucoma | Y <input type="checkbox"/> N <input type="checkbox"/> | Shingles |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Hay Fever | Y <input type="checkbox"/> N <input type="checkbox"/> | Sickle Cell Disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Heart Attack | Y <input type="checkbox"/> N <input type="checkbox"/> | Sinus Problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Heart Surgery | Y <input type="checkbox"/> N <input type="checkbox"/> | Stroke |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Hemophilia | Y <input type="checkbox"/> N <input type="checkbox"/> | Thyroid Problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Hepatitis | Y <input type="checkbox"/> N <input type="checkbox"/> | Tuberculosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Herpes/Fever Blisters | | |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following items?

- | | | | |
|---|--------------------|---|--------------|
| Y <input type="checkbox"/> N <input type="checkbox"/> | Aspirin | Y <input type="checkbox"/> N <input type="checkbox"/> | Latex |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> | Penicillin |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Dental Anesthetics | Y <input type="checkbox"/> N <input type="checkbox"/> | Tetracycline |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Erythromycin | Y <input type="checkbox"/> N <input type="checkbox"/> | Other |

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? Yes No

If Yes, please explain: _____

How would you describe the condition of your teeth and gums?
 Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums?
 Yes No If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? Yes No

Do your gums bleed when you floss? Yes No

Have you ever experienced pain in you jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: _____

Do you grind or clench your teeth? Yes No

Pre-medication Information

Have you ever required or been told that you require an antibiotic medication prior to dental treatment? Yes No

Do you have a heart murmur, heart defect, or valve replacement? Yes No

Do you have a joint replacement or implant? Yes No

Have you ever been treated for SBE? Yes No



I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes. I, the undersigned, hereby authorize Joyner Dental Arts o release dental information concerning the above patient.

Signature _____ Date _____

Patient portion is due in full at the time of treatment.