James T. Jesse, D.D.S.
Total Facial Esthetics

PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

PATIENT NAME _____ DATE _____

PREFERRED NAME _____ SSN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

HOME PHONE _____ CELL PHONE _____

BIRTHDAY _____ AGE _____ SEX _____

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ MINOR

☐ SEPARATED ☐ DIVORCED ☐ PARTNERED

PATIENT EMPLOYER / SCHOOL _____

OCCUPATION _____

EMPLOYER / SCHOOL ADDRESS _____

_____

EMPLOYER / SCHOOL PHONE _____

SPOUSE'S NAME _____ BIRTHDAY _____

IN CASE OF EMERGENCY, CONTRACT _____

PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE WITH

_____

NAME OF INSURANCE COMPANY(IES)

AND ASSIGN DIRECTLY TO DR. JESSE ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

_____ _____

DATE SIGNATURE

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO. _____

GROUP # _____

SUBSCRIBER'S NAME _____

BIRTHDAY _____ SSN _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

SECONDARY INSURANCE CO. _____

GROUP # _____

SUBSCRIBER'S NAME _____

BIRTHDAY _____ SSN _____

FINANCIAL AGREEMENT

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE. I AGREE THAT PARENTS/GUARDIANS ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR/CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE.

_____ _____

DATE SIGNATURE OF INSURED / GUARDIAN

MINOR / CHILD CONSENT

I, BEING THE PARENT OR GUARDIAN OF

_____

NAME OF MINOR / CHILD

DO HEREBY REQUEST AND AUTHORIZE THE DENTAL STAFF TO PERFORM NECESSARY DENTAL SERVICES FOR MY CHILD, INCLUDING BUT NOT LIMITED TO X-RAYS AND ADMINISTRATION OF ANESTHETICS WHICH ARE DEEMED ADVISABLE BY THE DOCTOR, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED.

_____ _____

DATE SIGNATURE OF INSURED / GUARDIAN

JAMES T. JESSE, D.D.S.
TOTAL FACIAL ESTHETICS

PATIENT REGISTRATION AND HISTORY (CONTINUED)

HEALTH HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THE BOXES THAT APPLY:

☐ AIDS / HIV	☐ CIRCULATORY PROBLEMS	☐ JAW PAIN	☐ SINUS TROUBLE
☐ ARTHRITIS	☐ DIABETES	☐ KIDNEY DISEASE	☐ SPECIAL DIET
☐ ARTIFICIAL HEART VALVES	☐ EPILEPSY	☐ LIVER DISEASE	☐ STROKE
☐ ARTIFICIAL JOINTS	☐ HEADACHES	☐ LOW BLOOD PRESSURE	☐ SWOLLEN NECK GLANDS
☐ BACK PROBLEMS	☐ HEART PROBLEMS	☐ NERVOUS PROBLEMS	☐ THYROID PROBLEMS
☐ BLOOD DISEASE	☐ HEPATITIS TYPE	☐ PSYCHIATRIC CARE	☐ ULCER
☐ CANCER	☐ HIGH BLOOD PRESSURE	☐ RESPIRATORY DISEASE	☐ VENEREAL DISEASE
☐ CHEMICAL DEPENDENCY	☐ JAUNDICE	☐ RHEUMATIC FEVER	☐ WEIGHT LOSS

HAVE YOU EVER USED BISPHOSPHONATE MEDICATION? BRAND NAMES ARE FOSAMAX, ACTONEL, ATELVIA, DIDRONEL, BONIVA. ☐ YES ☐ NO

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN?" THESE INCLUDE COMBINATION OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE). ☐ YES ☐ NO

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? _____

_____

DENTAL HISTORY

PLEASE CHECK YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	☐ YES	☐ NO	CLICKING JAW	☐ YES	☐ NO	GRINDING TEETH	☐ YES	☐ NO
LIP OR CHEEK BITING	☐ YES	☐ NO	ORTHODONTIC TREATMENT	☐ YES	☐ NO	SENSITIVITY TO COLD	☐ YES	☐ NO
BLEEDING GUMS	☐ YES	☐ NO	CLENCHING TEETH	☐ YES	☐ NO	GUMS SORE	☐ YES	☐ NO
LOOSE OR BROKEN TEETH	☐ YES	☐ NO	PAIN AROUND EAR	☐ YES	☐ NO	SENSITIVITY TO HEAT	☐ YES	☐ NO
BLISTERS IN MOUTH	☐ YES	☐ NO	DRY MOUTH	☐ YES	☐ NO	JAW PAIN	☐ YES	☐ NO
MOUTH BREATHING	☐ YES	☐ NO	PERIODONTAL TREATMENT	☐ YES	☐ NO	SENSITIVITY WHEN BITING	☐ YES	☐ NO

MEDICATIONS

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS: _____

_____

PHARMACY _____ PHONE _____

ALLERGIES

☐ ASPIRIN	☐ LATEX	☐ SULFA
☐ BARBITURATES	☐ LACAL ANESTHETIC	☐ OTHER : _____
☐ CODEINE	☐ PENICILLIN	
☐ IODINE	☐ SHELLFISH	

REASON FOR TODAY'S VISIT _____

FORMER DENTIST _____

DATE OF LAST DENTAL VISIT _____

WOMEN

DO YOU SUSPECT THAT YOU ARE PREGNANT? ☐ YES ☐ NO

ARE YOU NURSING? ☐ YES ☐ NO

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR USE IN MY TREATMENT, BILLING, AND PROCESSING OF INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ **DATE**

_____ **SIGNATURE**