JASON A. BANKS, DDS, PA – 1745A CITY CENTER BOULEVARD – ELIZABETH CITY, NC 27909
PHONE (252)331-2304 FAX (888)975-6590

Welcome

Thank you for selecting our dental office. To help us meet all your health care needs, please complete this form as accurately as possible. Thank you!

PATIENT INFORMATION

This appointment is for ☐ Yourself ☐ Your Child

Patient Name: _____ Preferred Name:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: _____ Social Security #: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

In the event of an emergency, who should we contact:
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Previous Dentist: _____ Previous Dentist Phone: _____
Current Physician: _____ Current Physician Phone: _____

DENTAL INSURANCE INFORMATION

Primary Dental Coverage ☐ Yes ☐ No

Subscriber Name: _____ Relation: _____
Subscriber Social Security #: _____ Subscriber Date of Birth: _____
Subscriber Employer: _____
Insurance Carrier: _____
Insurance Carrier Address: _____
Insurance Carrier Phone: _____
Group #: _____ ID#: _____

DENTAL HISTORY

Why have you come to the dentist today? _____
Do you require antibiotics before dental treatment?..... Yes____ No____
Are you currently in pain?..... Yes____ No____
Do your gums ever bleed?..... Yes____ No____
Have you ever had difficulties associated with any previous dental work?..... Yes____ No____
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?..... Yes____ No____
Have your tonsils and/or adenoids been removed?..... Yes____ No____
Are your teeth sensitive to heat, cold, or anything else?..... Yes____ No____
Do you use tobacco?..... Yes____ No____
Do you use controlled substances?..... Yes____ No____
Are you wearing contact lenses?..... Yes____ No____
Do you currently have a denture or partial plate?..... Yes____ No____

How many times do you: floss/week? _____ Brush/day?_____
When was your last dental cleaning? _____
When was your last dental visit? _____

MEDICAL HISTORY

ALLERGIES (PLEASE CHECK ALL THAT APPLY)

☐ Aspirin ☐ Erythromycin ☐ Latex
☐ Codeine ☐ Hay Fever ☐ Metals
☐ Dental Anesthetics ☐ Penicillin ☐ Sulfa
☐ Other: _____

IF FEMALE, PLEASE ANSWER

Are you taking birth control pills?
Are you pregnant? _____
If so, # of weeks? _____
Are you nursing? _____

MEDICAL CONDITIONS (PLEASE CHECK ALL THAT APPLY)

☐ Abnormal Bleeding
☐ Alcohol Abuse
☐ Allergies
☐ Anemia
☐ Angina Pectoris
☐ Artificial Heart Valve
Date: _____
☐ Arthritis
☐ Asthma
☐ Blood Disease
☐ Cancer
Type: _____
Date: _____
☐ Chemotherapy
☐ Cholesterol
☐ Colitis
☐ Congenital Heart Defect
☐ COPD
☐ Diabetes
☐ Difficulty Breathing
☐ Drug Abuse
☐ Emphysema
☐ Epilepsy
☐ Facial Surgery
☐ Fainting Spells
☐ Fever Blisters
☐ Fibromyalgia
☐ Frequent Headaches
☐ Glaucoma
☐ Head Injuries
☐ Heart Attack
Date: _____
☐ Heart Murmur
☐ Heart Surgery
Type: _____
Date: _____
☐ Hemophilia
☐ Hepatitis
A___ B___ C___ D___ E___
☐ High Blood Pressure
☐ HIV + AIDS
☐ Joint Replacement
Type: _____
Date: _____
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pace Maker
☐ Psychiatric/Mental Disorders
Type: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Seizures
☐ Sexually Transmitted Disease
Type: _____
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
Date: _____
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Other: _____

Please list your current medications: _____

_____

_____

_____

_____

_____

_____

_____

IMPORTANT QUESTIONS

■ Have you ever taken Zometa or Aredia for any of the following: Multiple Myeloma, Lung or Breast Cancer, or Paget's Disease of the bone? These are IV drugs given to stop the spread of aggressive cancers to bone.

☐ Yes ☐ No If Yes, please list date(s) taken:

■ Have you ever taken Fosamax, Actonel, Boniva or Arsever for osteoporosis? ☐ Yes ☐ No

If Yes, please list date(s) taken:

ACKNOWLEDGMENT AND AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, Parent, or Guardian

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ACKNOWLEDGMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICE

* You May Refuse to Sign this Acknowledgment *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgment

□ An emergency situation prevented us from obtaining acknowledgment

□ Other (Please Specify)

_____

_____

_____