Heather Jordan, DDS

PATIENT INFORMATION

Name ______ Birthdate ______ Home Phone (____) ______

Address ______ City ______ State ______ Zip ______

Sex ☐M ☐F ☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ____ years

E-mail ______ Cell Phone #1 (____) ______ Cell Phone #2 (____) ______

Employer/School ______ Employer/School Phone (____) ______

Employer/School Address ______ City ______ State ______ Zip ______

Spouse or Parent's Name ______ Employer ______ Work Phone (____) ______

Whom may we thank for referring you? ______

Person to contact in case of emergency ______ Phone (____) ______

RESPONSIBLE PARTY

Name of Person Responsible for this Account ______ Relation to Patient ______

Address ______ Home Phone (____) ______

Social Security # ______ Birthdate ______ Bank ______

Employer ______ Work Phone (____) ______

Currently a patient in our office? ☐Yes ☐No E-mail ______ Cell Phone (____) ______

INSURANCE INFORMATION

Name of Insured ______ Relation to Patient ______

Birthdate ______ Social Security # ______ Date Employed ______

Employer ______ Work Phone(____) ______

Employer Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group # ______ Union or Local # ______

Address ______ City ______ State ______ Zip ______

How much is your deductible? ______ How much have you used? ______ Max. Annual Benefit ______

ADDITIONAL INSURANCE

Name of Insured ______ Relation to Patient ______

Birthdate ______ Social Security # ______ Date Employed ______

Employer ______ Work Phone(____) ______

Employer Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group # ______ Union or Local # ______

Address ______ City ______ State ______ Zip ______

How much is your deductible? ______ How much have you used? ______ Max. Annual Benefit ______

Authorization and Release

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

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission. Dr. Jordan may use my health care information and may disclose such information to my insurance company for the purpose of obtaining payment for services and determining insurance benefits.

Signature: ______ Date: ______

Heather
Jordan, DDS

406-453-6459
heatherjordanddsegmail.com
300 Park Drive South, Ste 203
Great Falls, MT, 59405

Welcome

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (Last, First, M.I.):		☐ M ☐ F	DOB:	
Previous or referring doctor:		Date of last exam:		

PERSONAL HEALTH HISTORY

SOME MEDICAL CONDITIONS MAY AFFECT YOUR ORAL HEALTH. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Are you allergic to any of the following?	☐ Anesthetics	☐ Metals	☐ Latex	☐ Other Please List
	☐ Codeine	☐ Penicillin	☐ Antibiotics	
	☐ Aspirin	☐ Tebracycline	☐ Erythromycin	

PLEASE CHECK ANY OF THE CONDITIONS YOU MAY HAVE HAD IN THE PAST

☐ Anemia	☐ Asthma	☐ Drug or Alcohol Abuse	☐ Frequent Headaches
☐ Angina/Chest pain	☐ Cancer/Chemotherapy	☐ Emphysema	☐ Neck or Shoulder Pain
☐ Artificial Joints/Replacements	☐ Congenital Heart Defect	☐ Epilepsy or Seizures	☐ Glaucoma
☐ Artificial Valves	☐ Diabetes	☐ Fainting Spells	☐ Heart Attack/Stroke
☐ Arthritis	☐ Difficulty Breathing	☐ Fever Blisters or Herpes	☐ Heart Murmur
☐ Heart Surgery/Pacemaker	☐ High/Low Blood Pressure	☐ Malignancies	☐ Radiation Treatment
☐ Hemophilia/Abnormal Bleeding	☐ High Cholesterol	☐ Mitral Valve Prolapse	☐ Rheumatic/Scarlet Fever
☐ Hepatitis	☐ HIV/Aids	☐ Neurological Problems	☐ Shingles
☐ STD	☐ Thyroid Problems	☐ Tuberculosis	☐ Ulcers/Colitis
☐ Other Please Specifiy			

For Women	Are you taking birth control pills ☐ Y ☐ N	Are You Pregnant ☐ Y ☐ N WK#	Are You Nursing ☐ Y ☐ N

ARE YOU TAKING ANY PRESCRIPTION DRUGS OR HERBAL MEDICATIONS? PLEASE LIST

ARE YOU TAKING ANY BISPHOSPHONATES? FOSAMAX BONIVA ACTONEL ZOMETA ______

ARE YOU TAKING ANY BLOOD THINNERS? CUMADIN PLAVIS HEPARIN LOVENOX ______

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

Signature:	Date:

For office use only

Date	Updated Information	Initials	Date	Updated Information	Initials

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Welcome

Dental History

How long since you have seen a dentist?______________________________

Name of previous Dentist:______________________________________

Last complete dental exam?______________________________________

Last Full Mouth X-Ray date?_____________________________________

Do your wear Dentures? (Partial/Full)________________________________

Are you Apprehensive about dental treatment?_________________________

Please check if you have any of the following:

Bad Breath	**Bleeding gums**	**Clicking or popping jaw**
Grinding teeth	**Loose or broken fillings**	**Sensitivity to cold/hot**
Sensitive to sweets	**Worn Braces (orthodontics)**	**Peridontal treatments**
Pain around your ears/neck	**Mouth sores**	**Unpleasant taste**

Would you like to know your options to:

Improve your smile	look younger	keep your teeth
have fillings last longer	avoid painful episodes	

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Welcome

FINANCIAL OPTIONS

We fully believe dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we do provide a number of payment options.

INSURANCE: As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We can estimate and will assist you in determining your insurance benefits. Any uninsured portion is due at the time of service. If for any reason, the estimated amount is not paid by your insurance company, you will be responsible for the unpaid balance.

We encourage you to overview your policy in detail so that you are aware of your plan's specifics and maximum coverage.

NON-INSURED AND SELF PAY: Payment in full is required at time of service.

PAYMENT OPTIONS:

Please check the box that applies to you.

[ ] Payment in full- A 3% courtesy will be given for payment in full at time of service

[ ] Payment by cash, check or credit card for portion your insurance does not cover

MISSED APPOINTMENTS: We ask that you give at least 48 hours notice if you are unable to make your scheduled appointment. Cancellation fees will be charged for missed appointments or for those cancelled without at least 24 hours notice.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and understand that 18% interest will be applied annually to any outstanding balances of 60 days. I authorize the dentist to release any information required for this claim. I certify that I have read the contents of this form and financial policy.

Signature of guarantor of payment/responsible party:

Signature: ______________________________ Date: