Jason L. Montgomery, D.D.S.
Patient Information

Date_____ **Date of Birth** _____

Name_____ **Sex M**____ **F**____ **Social Security#** _____

Address_____

City_____ **State**_____ **Zip** _____ **Email**_____

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

Employer _____

Insurance Information: **Name of Insured:** _____ **ID#**_____

Name of Insurance Co: _____ **Group#**_____ **Contact#**_____

Spouse's Information: **Spouse's Name** _____ **Date of Birth** _____

Spouse's Employer _____ **Social Security #**_____

Whom may we thank for referring you? _____

Emergency Contact _____ **Phone** _____

Reason for initial visit today:_____ **Date and reason of last dental exam** _____

Dental History: ***Place a check if you have or have had problems with any of the following:***

Bad breath	○	Food collection between teeth	○	Pain around ear	○
Bleeding or swollen/tender gums	○	Grinding teeth	○	Periodontal therapy	○
Blisters/sores/growths on lips or mouth	○	Jaw pain/tiredness	○	Sensitivity to cold	○
Burning sensation on tongue	○	Lip or cheek biting	○	Sensitivity to heat	○
Chew on one side of mouth	○	Loose teeth	○	Sensitivity to sweets	○
Smoke/Chew tobacco	○	Broken fillings	○	Sensitivity when biting	○
Dry mouth	○	Mouth pain	○	How often do you floss? _____	
Fingernail biting	○	Orthodontic treatment	○	How often do you brush? _____	

Is there anything you would like to change about your smile? _____

I authorize my insurance company to pay the dentist directly. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient, parent or guardian _____

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Medical History: ***Place a check mark if you have or have had any problems with any of the following:***

AIDS/HIV	○	Glaucoma	○	Radiation Treatment	○
Anemia	○	Headaches	○	Respiratory Disease	○
Arthritis, Rheumatism	○	Heart Attack	○	Rheumatic Fever	○
Artificial Heart Valve	○	Heart Murmur	○	Scarlet Fever	○
Artificial Joints	○	Heart Disease	○	Shortness of Breath	○
Asthma	○	Hemophilia	○	Seizures	○
Abnormal Bleeding	○	Hepatitis Type _____	○	Sinus Trouble	○
Cancer Therapy	○	Herpes	○	Stroke	○
Chemical Dependency	○	High Blood Pressure	○	Swollen Feet or Ankles	○
Chemotherapy	○	Kidney Disease	○	Swollen Neck Glands	○
Congenital Heart Problems	○	Latex Allergy	○	Thyroid Problems	○
COPD	○	Leukemia	○	Tonsillitis	○
Cortisone Therapy	○	Liver Disease	○	Tuberculosis	○
Cough, persistent or bloody	○	Low Blood Pressure	○	Tumor or growth on head/neck	○
Diabetes	○	Mitral Valve Prolapse	○	Ulcer	○
Emphysema	○	Neurological Problems	○	Weight loss, unexplained	○
Endocarditis	○	Pacemaker	○	Other:_____	○
Epilepsy	○	Psychiatric Care	○		

Current Medications: _____

Allergies to Medications: _____

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check any medications you are presently taking, taken in the past, or have had adverse reactions to.

	Present	Past	Reaction		Present	Past	Reaction
Anesthetics, Locally Injected	○	○	○	Blood Thinners	○	○	○
Anesthetics, General	○	○	○	Dilantin	○	○	○
Antacids	○	○	○	Diuretics (water pill)	○	○	○
Anti-anxiety Medication	○	○	○	Fen-Phen (Ionimin, Adipex, Fastin, Phentermine, Pondimin, Fenfluramine, Redux, Desfenfluramine)	○	○	○
Anti-depressants	○	○	○	Heart Medications	○	○	○
Antihistamines	○	○	○	Ibuprofen (Motrin/Advil)	○	○	○
Daily Aspirin Regimen	○	○	○	Insulin or Diabetic Medication	○	○	○
Birth Control Pills	○	○	○	Sedatives or Tranquilizers	○	○	○
Blood Pressure Medication	○	○	○	Sleeping Pills (barbiturates)	○	○	○
Codeine, Demerol or Analgesics	○	○	○	Thyroid Medications	○	○	○
Cortisone/Steroids	○	○	○	Tylenol (acetaminophen)	○	○	○
Street Drugs /Frequency	○	○	○	Alcohol, beer, wine -/drinks per day _____			

Tobacco/packs per day _____

Women: Pregnant? _____ Are you currently nursing? _____ Taking birth control? _____

List any surgeries or serious illness and dates associated: _____

Do you have any other health needs that you should bring to our attention? _____

To the best of my knowledge, the above information is correct. I understand it is my responsibility to inform my doctor if there are any changes in my health.

Signature of Patient or Personal Representative:_____ Date: _____