Robert B. Jacob, D.D.S.

TEAM BRACES // ORTHODONTIST

MEDICAL HISTORY INFORMATION

Patient Name:_____ Date of Birth: _____

Medical: Physician's Name: _____ Phone # _____

Please circle the appropriate answer:

Medical Record # _____

Yes No … Are you in good health?

Do you have any history of the following:

Yes No … Heart problems?
Yes No … Pain in your chest or shortness of breath?
Yes No … Artificial heart valves or joints?
Yes No … Rheumatic Fever?
Yes No … High or low blood pressure?
Yes No … Angina?
Yes No … Allergy? (Other than seasonal)
Yes No … Asthma?
Yes No … Other respiratory problems, emphysema, etc?
Yes No … Arthritis?
Yes No … Cancer or tumor?
Yes No … Diabetes?
Yes No … Blood disorders, anemia, etc?
Yes No … Epilepsy or other seizure disorders?
Yes No … Immune disorders?
Yes No … Infectious hepatitis?
Yes No … AIDS or HIV positive?
Yes No … Tuberculosis?
Yes No … Sexually transmitted disease?
Yes No … Osteoporosis?
Yes No … Using tobacco products?
Yes No … Substance Abuse?

For Women:

Yes No … Are you taking birth control medication?
Yes No … Are you pregnant?

List all current medications:

List all allergies:

DENTAL:

Dentist's Name: _____ Phone: _____
Address: _____
Last dental check up: [ ] Less than 6 months [ ] 6 to 12 months [ ] more than 12 months

Yes No … Is all dental work completed?
Yes No … Have you ever worn braces or retainers?
Yes No … Do your gums bleed regularly when you brush or floss?
Yes No … Do you have any pain or sores in your mouth at this time?
Yes No … Does your jaw click or pop regularly?

Additional Physicians or Dentists:

Name: _____ Specialty: _____ Phone: _____
Name: _____ Specialty: _____ Phone: _____
Name: _____ Specialty: _____ Phone: _____

Signature: _____ Printed Name: _____Date: _____ _____

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INSURANCE INFORMATION

Please print. Complete all applicable sections of this form. All information will remain confidential.

Patient Name:_____ Date of Birth: _____ Sex: M F

SS#: _____-____-_____ Drivers License #: _____

Phone: Home (____)_____-_____ Cell (____)_____-_____

Address: _____ City: _____ State: ___ Zip: _____

E-MAIL: _____

[ ] No orthodontic insurance at this time
[ ] Patient enrolled in Medical (Hospital) Insurance
[ ] Patient enrolled in CCS (California Children's Services)
[ ] Patient enrolled in TRICARE
[ ] Patient enrolled in Medi-Cal

Adult Patients: Complete this section

Employer: _____
Address: _____
Work Phone: _____
Insurance Name: _____
Plan: _____ Group: _____
[ ] HMO [ ] PPO

Spouse (If coverage is thru spouse's work)

Name: _____
SSN: _____-____-_____ DOB: _____
Employer: _____
Address: _____
Work Phone: _____
Insurance Name: _____
Plan: _____ Group: _____
[ ] HMO [ ] PPO

For Minor Patients: Complete this section

Marital status of parent(s): [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Mother Primary on insurance [ ]
Name _____
Cell Phone #:_____
DOB: _____ Responsible party [ ]yes [ ] no
Address if different from above:
_____
_____
SSN: ___-___-_____ Drivers License: _____
Insurance Name: _____
Plan: _____ Group: _____
[ ] HMO [ ] PPO Employer: _____

Father Primary on insurance [ ]
Name: _____
Cell Phone #:_____
DOB: _____ Responsible party [ ]yes [ ] no
Address if different from above:
_____
_____
SSN: ___-___-_____ Drivers License: _____
Insurance Name: _____
Plan: _____ Group: _____
[ ] HMO [ ] PPO Employer: _____

Who does patient live with? [ ] Both parents [ ] Mom [ ] Dad [ ] Other: _____

To whom should we send correspondence? [ ] Both parents [ ] Mom only [ ] Dad only

Please bring any applicable insurance cards to your first visit.