

# Jason B. Cellars, D.D.S.

Thank you for choosing our office for your dental treatment. In order that we may be more effective in meeting your needs, please complete this entire form in full.

Name _____	Age _____	Spouse's Name _____
Residence Address _____	City _____	Zip _____
Mailing Address _____	City _____	Zip _____
Residence Phone _____	Cell Phone _____	E Mail _____
Driver's License No. _____	Social Security No. _____	Birth Date _____
Married _____	Single _____	Divorced _____
Separated _____	Widowed _____	
Employed by _____	Occupation _____	
If Self-employed, name of business _____		
Business Address _____	Bus. Phone _____	
Spouse Employed by _____	Occupation _____	
If Self-employed, name of business _____		
Bus. Phone _____		
Name of nearest relative not living with you _____		Relation _____
Address _____		Phone _____
Name of Physician _____	City _____	Phone _____
Former Dentist _____	City _____	Phone _____
Purpose of Appointment _____		
Is this visit for emergency dental care? _____		
How did you hear about our office? _____		

Person responsible for this account _____	Relation _____
Address _____	Phone _____
Insurance Company Name _____	Group No. _____
Social Security Number of Insured _____	Insured Birth Date _____
Secondary Insurance Company Name _____	Group No. _____
Social Security Number of Insured _____	Insured Birth Date _____

Comments _____
_____
_____

**Please complete other side**

# Medical History

1. Are you under medical treatment now?.....yes no  
Explain \_\_\_\_\_
2. Have you had a joint or heart valve replaced?...yes no
3. Are you allergic to any of the following?  
Are you allergic to Latex?.....yes no  
Local anesthetics (e.g. Novocaine, etc).....yes no  
Aspirin.....yes no  
Codeine.....yes no  
Penicillin.....yes no  
Erythromycin.....yes no  
Tetracycline or other antibiotics.....yes no  
Other \_\_\_\_\_
4. Do you use tobacco?.....yes no
5. Do you take medication for osteoporosis? For example, Fosamax or Boniva.....yes no
6. Do you use recreational drugs (ie. cocaine)?....yes no
7. Are you taking any medications including non-prescription medicine?.....yes no  
If yes, what medication(s) are you taking \_\_\_\_\_  
\_\_\_\_\_
8. Women only:  
a) Are you pregnant or think you may be?.....yes no  
b) Are you taking birth control pills?.....yes no
9. Do you have or have you had any of the following? (Please check known conditions)  

___ High Blood Pressure	___ Liver Disease	___ Arthritis
___ Heart Disease	___ Asthma	___ Sinus Trouble
___ Rheumatic Fever	___ Epilepsy/Convulsions	___ Nervous Disorders
___ Diabetes	___ AIDS or HIV infection	___ Dry Mouth
___ Hepatitis/Jaundice	___ Kidney Disease	___ Difficulty with Swallowing
___ Mitro Valve Prolapse (MVP)	___ Tuberculosis	___ Excessive Bleeding
___ Heart Attack	___ Sexual Transmitted Disease	___ Tumors/Growths
___ Stroke	___ Herpes	___ Angina
___ Cancer	___ Allergies/Hay Fever	___ Osteoporosis
___ Heart Murmur	___ Glaucoma	___ Other _____

# Dental History

1. How long has it been since your last complete series of oral X-rays(not check up X-rays)? \_\_\_\_\_
2. How long since your last dental treatment? \_\_\_\_\_
3. Have you ever had local anesthetic (novocaine).....yes no
4. Have you ever had any serious trouble with any previous dental treatment?.....yes no
5. Have you ever been told that you have gum disease (pyorrhea)?.....yes no
6. Do you clench or grind your teeth?.....yes no
7. Do you snore?.....yes no
8. Does dental treatment make you nervous.....yes no If yes, \_\_\_slightly\_\_\_ moderate \_\_\_extremely
9. Would you desire to be pre-sedated or use Nitrous oxide?.....yes no
10. Is it important to you to keep your natural teeth?.....yes no
11. If you could wave a magic wand and change anything about your smile, what would it be? \_\_\_\_\_  
\_\_\_\_\_
12. If there was a simple, inexpensive way to whiten your teeth, would you be interested? \_\_\_\_\_
13. Why did you leave your last dentist? \_\_\_\_\_
14. What did you like most about any dentist you=ve ever seen? \_\_\_\_\_
15. What did you like least about any dentist you=ve ever seen? \_\_\_\_\_

# Consent

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have changes in my health, or if my medicines change, I will inform the doctor. I authorize the doctor to take radiographs, study models or any other diagnostics aids deemed appropriate in order to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment , medication and therapy, that may be indicated after proper explanation, alternatives and consequences have been given to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_