# WILLIAM J. JONES, D.D.S.
# PHILLIP W.R. JONES, D.D.S.

**1 South Main St.**
**Villa Grove, IL 61956**
**Phone (217) 832-7011/Fax (217) 832-7011**

Today's Date: ____ / ____ / ____

**ABOUT YOU**

Patient Name (First, Middle, Last): _____ Preferred Name: _____ □ Male □ Female

Patient Date of Birth: ___/ ___/ ___ Age: ____ Social Security #: _____ Dr. Lic. #: _____

Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Home #: ( ____ ) _____ Cell #: ( ____ ) _____ {Ok to text? □ Yes □ No} Work #: ( ____ ) _____

E-mail address: _____ {Ok to e-mail? □ Yes □ No} Referred By: _____

Mailing Address: _____ City_____ State_____ Zip_____

Employer Name/Address: _____ Employer #: ( _____ ) _____

How long have you worked for this company? _____ Occupation: _____

Spouse's Name (if applicable): _____ Do you have children? □ No □ Yes/How many?_____

**INSURANCE INFORMATION**

**Primary Dental Insurance**
Company Name/Address: _____ Phone #: ( _____ ) _____

Insured's Name: _____ Relation: _____ Insured's ID/SS#: _____

Insured's Date of Birth: ____ / ____ / ____ Insured's Employer/Address: _____

**Secondary Dental Insurance**
Company Name/Address: _____ Phone #: ( _____ ) _____

Insured's Name: _____ Relation: _____ Insured's ID/SS#: _____

Insured's Date of Birth: ____ / ____ / ____ Insured's Employer/Address: _____

**IN EVENT OF EMERGENCY**

Whom should we contact? _____ Relation: _____

Home #: ( _____ ) _____ Cell #: ( _____ ) _____ Work #: ( _____ ) _____

Who is your medical doctor? _____ Medical Doctor's Phone # ( _____ ) _____

**-- PLEASE CONTINUE ON BACK --**

**DENTAL INFORMATION**

Reason for today's visit: □ Exam □ Emergency □ Consultation --- Are you in pain? □ Yes □ No

Indicate any of the following problems: □ Discomfort, clicking or popping in jaw □ Lost/Broken Filling(s) □ Stained Teeth
□ Locking Jaw □ Teeth Grinding □ Red, swollen or bleeding gums □ Ringing in Ears □ Bad breath
□ Loose Tooth □ Broken/Chipped Tooth □ Sensitive tooth, teeth or gums □ Blisters/Sores in or around the mouth
□ Other(s): _____

Do you require pre-medication? □ Yes □ No □ Don't know
Times a day you brush? ___ Times a week you floss? ___ What type of tooth brush bristles do you use? □ Soft □ Medium □ Hard
Previous Dentist/Address: _____ Phone #: ( _____ ) _____
Last Dental Exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____ Is your water fluoridated? □ Yes □ No

**MEDICAL HISTORY**

Are you taking any of the following medications? □ Nerve pills □ Pain Killer (including Asprin) □ Stimulants □ Blood Thinners
□ Tranquilizers □ Insulin □ Muscle relaxers □ Others: _____

Do you have or ever had any of the following diseases, medical conditions or procedures?

| | | | |
|---|---|---|---|
| **Y N** Heart Murmurs | **Y N** Tonsilitis | **Y N** High/Low Blood Pressure | **Y N** Stomach Problems |
| **Y N** Respiratory Problems | **Y N** Hepatitis | **Y N** Sinus Problems | **Y N** Athma/DifficultyBreathing |
| **Y N** Artificial Bones/Joints/Implants | **Y N** Congenital Heart Defect | **Y N** Blood Transfusion(s) | **Y N** Organ Problems |
| **Y N** Scarlet Fever or Rheumatic Fever | **Y N** Leukemia/Anemia | **Y N** HIV+/AIDS/ARC | **Y N** Heart Attack/Stroke |
| **Y N** Diabetes/Hypoglycemia | **Y N** Tuberculosis TB | **Y N** Cancer/Tumors | **Y N** Hemophilia |
| **Y N** Psychiatric Problems | **Y N** Chemotherapy | **Y N** Bleeding Problems | **Y N** heart Disease |
| **Y N** Jaw Problems TMJ/TMD | **Y N** Mitral Valve Prolapse | **Y N** Fainting/Seizures/Epilepsy | **Y N** Hearing Problems |
| **Y N** Heart Surg./Pacemaker | **Y N** Cerebral Palsy | **Y N** Glaucoma | **Y N** Emphysema |
| **Y N** Alcohol/drug abuse | **Y N** Severe or frequent headaches | **Y N** Cerebral Palsy | **Y N** Arthritis/Rhematism |
| **Y N** Venereal Disease | | | |

Please list any other surgeries or medical condition(s) you have or ever had: _____

Are you allergic to: □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Dental Anesthetics(Novacaine) □ Asprin □ Others: _____
Please rate your general health: **Worst** 1 2 3 4 5 6 7 8 9 10 **Best** Blood Type: _____
Do you use tobacco? □ No □ Yes/How used? _____ How much? _____ How long? _____
Have you ever taken the drug Phen-fen and or Redux? □ Yes □ No -- Do you wear contact lenses? □ Yes □ No
**For women:** Are you taking Birth Control pills? □ Yes □ No How many children have you had?_____
Are you pregnant? □ No □ Yes/How far along are you? _____ Are you nursing? □ Yes □ No

**ACCOUNT INFORMATION**

Payment Method: □ Cash □ Check □ Credit Card _____ Exp: ____ / ____

_____ (initials) - I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

- We request that patients pay co-pays and deductibles at the time of service. Benefits paid by insurance companies vary greatly from carrier to carrier and plan to plan. We do expect the patient to be aware of their benefits and coverage for their particular insurance policy. We would like you to present a current insurance card at every appointment. We will file insurance claims, as well. However, the patient is ultimately responsible for payment expenses incurred in the course of treatment at the time of treatment. For our self pay patients, payment is due at the time of service.
- Unpaid balances will be billed by monthly statement. All unpaid balances that are not awaiting an insurance payment will be assessed a finance charge of 1.5% monthly (18% annually). Failure to resolve payment within 60 days will be subject to collection procedures, and the patient and/or responsible party shall be responsible for collection costs of 50% of the balance due plus attorney fees totaling 33% of balance plus court costs. There is a $25 charge for the following services: returned checks, completion of forms, and letter writing.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I read and understand the WILLIAM J. JONES, D.D.S. & PHILLIP W.R. JONES, D.D.S. Notice of Privacy Practices.

Signature of Responsible Party _____ □ Self □ Other: _____ Date ____ / ____ / ____