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JABS Family Dentistry
www.Jabsdentistry.com

WELCOME **At Jabs Family Dentistry, we appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health since your last visit, please let us know. If you have any questions, don't hesitate to ask – we will be happy to help.**

Patient name:_____ **Date of birth:**_____ **Sex:**_____ **Age:**_____

Home Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Billing Address (If Different)**:**_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell:**_____ **E-mail:**_____

Social Security #:_____ **Employer/Occupation:**_____ **Work Phone:**_____

Spouse/Guardian Name:_____ **Spouse/Guardian Phone:**_____

Primary Dental Insurance:_____ **Member ID:**_____ **Group #:**_____

Subscriber's Name:_____ **Relationship to Patient:**_____

Date of Birth:_____ **Social Security #:**_____

If Applicable: **Secondary Dental Insurance:**_____ **Member ID:**_____ **Group #:**_____

Subscriber's Name:_____ **Relationship to Patient:**_____

Date of Birth:_____ **Social Security #:**_____

Referred To Us By:_____

For your convenience, we offer the following methods of payment. Please check the option that you prefer.
We offer a 5% discount on payment in full for same day services when paid with check or cash.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ Visa ☐ MasterCard
☐ Care Credit ☐ I wish to discuss the office's payment policy

Dental Health History

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet/sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐
Do your gums bleed while brushing/flossing?	☐	☐

	Yes	No
Have you ever experienced pain or clicking in your jaw?	☐	☐
Do you clench or grind your teeth frequently?	☐	☐
Do you have frequent headaches?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Have you had braces or orthodontic treatment?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had any difficult extractions in the past?	☐	☐
Have you had prolonged bleeding after an extraction(s)?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐

(Continued on Reverse)