Robert B. Jacob, D.D.S.

TEAM BRACES // ORTHODONTIST

DEMOGRAPHIC & INSURANCE INFORMATION

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

Date: _____

Patient Name:_____ Date of Birth: _____

SS#: _____-____-_____ Sex: M F [identifies as: M F]

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

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

Primary e-mail address:_____

[ ] Patient enrolled in Medi-Cal (California Medicaid)
[ ] Patient enrolled in TRICARE [ ] PRIME [ ] STANDARD

Dental Insurance: Complete this section

Primary Insured: _____

Relationship: __ Self __ Spouse __ Dependent

Insurance Name: _____

ID# _____

[ ] HMO [ ] PPO

Primary insured SS #: _____

Primary Insured date of Birth: _____

Medical Insurance: Complete this Section

Primary Insured: _____

Relationship: __ Self __ Spouse __ Dependent

Insurance Name: _____

ID #_____

Group # _____

[ ] HMO [ ] PPO

Primary Insured SS# _____

Primary Insured date of Birth: _____

For Minor Patients: Complete this section

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

Parent/Guardian 1

Relationship to patient: _____

Name: _____

Cell Phone #:_____

DOB: _____

Address if different from above:

_____

_____

SSN: ___-___-_____ Drivers License: _____

Parent/Guardian 2

Relationship to patient: _____

Name: _____

Cell Phone #:_____

DOB: _____

Address if different from above:

_____

_____

SSN: ___-___-_____ Drivers License: _____

Please bring both medical & dental insurance cards to your first visit.

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?
Yes No … Snoring / Sleep Apnea

List all current medications:

List all allergies:

For Women:

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

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: _____