JON C. PACKMAN DDS
general dentistry

Jon C. Packman, DDS, PLLC
1316 Davie Avenue, Suite A
Statesville, NC 28677
704.873.2211
www.statesvilledentalcare.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:	Send appointment reminders via: Text Message Email Mail

Please tell us where you heard about us (check all that apply):

Friend or Relative (name): Newspaper Ad Radio Ad Ad in Mail
Saw our Office Insurance Company Our Website Search Engine (Google, etc.)
Other Website: Other:

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Emergency_Contact Address:	City:	State:	ZIP Code:

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Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Holder of Dental Insurance for Patient:
/ /	- -	

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Jon C. Packman, DDS, PLLC to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Jon C. Packman, DDS, PLLC. I permit a copy of this authorization to be used in place of the original. I give Jon C. Packman, DDS, PLLC, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /

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Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Jon C. Packman, DDS, PLLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Jon C. Packman, DDS, PLLC to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Dental History

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? Yes No

What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: /	Last Cleaning: /

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

What is the main reason for your visit today?

Tooth Pain   Check-up   Cleaning   Whitening   Cosmetic Dentistry
Restorative Dentistry   Other:

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Dental Concerns

Check all that apply.

Teeth

Broken or chipped	Loose/missing filling	Missing teeth	Sensitive to sweets
Crooked	Loose teeth	Mouth sores	Blisters on lips/mouth
Decay	Tooth pain	Sensitive to cold	Orthodontic treatment
Difficulty chewing	Food trap areas	Sensitive to heat	Bad taste in mouth
Discolored	Grinding or clenching	Sensitive when biting	

Gums

Bad breath	Abscessed	Sore	Receding
Red (discolored)	Bleeding	Swollen	Periodontal treatment

Facial/Jaw Pain

Frequent headaches	Pain in temples	Jaw injury	Pain around ear
Avoid certain foods	Jaw locks open/closed	Head injury	
Popping/clicking	Pain in jaw	Neck injury	

Other Concerns

Smoking/dipping	Orthodontic treatment	Snoring
Biting cheeks or lip	Burning tongue	Teeth straightening
Popping/clicking	Tooth replacement	Retainer
TMJ	Fractured tooth syndrome	Dry mouth
Tooth-colored fillings	CPAP	Wisdom teeth extraction
Wisdom teeth	Implants - Tooth #:	Cosmetics
Nail-biting	Jaw locks open/closed	Smile makeover
Sleep apnea	Stain	Dental phobias
Limited orthodontics	Chew on one side	

Does food tend to get caught between your teeth? If yes, where?

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Have you ever had:

Check all that apply.

Orthodontic treatment	Periodontal treatment	Your bite adjusted
Oral surgery	Your teeth ground	A bite plate or mouth guard

Any canker sores or cold sores on your lips, tongue, gums, or body

A serious injury to the mouth or head? If yes, please describe including cause:

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Miscellaneous

Has fear ever been an issue for you in a dental office? Yes No

Has time ever been a factor in getting your dental work done? Yes No

Has the cost of dental treatment been a concern for you? Yes No
If yes, how can we help?

Tell us about your bad dental experiences/fears:

Is there anything else you feel we should know?

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Phone: - -	Last Visit: /

Address:	City:	State:	ZIP Code:

Do we have permission to contact your doctor regarding your care? Yes No

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Have you ever had:

Check all that apply.

- Arthritis
- Arteriosclerosis
- Birth defects
- Cancer
- Emotional problems
- Head or face injury
- Heart murmur/trouble
- History of substance abuse/drug addiction
- Kidney problems
- Numbness of arms or hands
- Swollen, still painful joints
- Allergies
- Asthma
- Blood disease
- Diabetes
- Endocrine problems
- Intestinal disorders
- Hepatitis A, B, or C
- Hypertension (high blood pressure)
- Liver problems
- Pneumonia
- Shortness of breath
- Anemia
- Bruise easily
- Dizziness
- Epilepsy
- Seizures
- Fainting
- Hearing disorders
- High or low blood sugar
- Hypotension (low blood pressure)
- Nervous disorder
- Rheumatic fever
- Heart attack/stroke
- Heart surgery
- Pacemaker
- Artificial valves
- Congenital heart defect
- Mitral valve prolapse
- Artificial bones/joints
- Shingles
- HIV/AIDS
- Blood transfusions
- Fever blisters
- Sinus problems
- Severe/frequent headaches
- Cancer/chemotherapy
- Radiation treatments
- Psychiatric problems
- Tuberculosis
- Venereal disease
- Hemophilia
- Abnormal bleeding
- Ulcers/colitis
- Difficulty breathing
- Hospitalized for any reason
- Emphysema
- Glaucoma
- Thyroid disease
- Angina
- Artificial hip/joints
- Gout
- Chest pain
- Circulatory problems
- Cold sores
- Congenital heart lesion
- Cortisone medicine
- Convulsions
- Herpes
- Leukemia
- Excessive thirst
- Hay fever
- Heart disease
- Hives/skin rash
- Hypoglycemia
- Irregular heartbeat
- Lung disease
- Osteoporosis
- Pain in jaw joints
- Parathyroid disease
- Recent weight loss
- Rheumatism
- Scarlet fever
- Sexually transmitted disease
- Sickle cell anemia
- Sinus trouble
- Tattoos/body piercing
- TMD/TMJ (jaw pain)
- X-ray or cobalt treatment
- Yellow jaundice
- Chronic fatigue syndrome
- Cough-persistent or bloody
- Latex sensitivity
- Smoker
- Swelling of feet/ankles
- Swollen neck glands
- Tonsillitis
- Tumor or growth on head/neck
- Easily winded
- Anaphylaxis
- Alzheimer's disease
- Frequent diarrhea
- Genital herpes
- Renal dialysis
- Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- Acrylic
- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Dental anesthetics
- Erythromycin
- Iodine
- Latex rubber
- Metals
- Nitrous oxide
- Novocaine
- Penicillin/antibiotics
- Sedatives
- Sulfa drugs
- Tetracycline
- Valium
- Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No

Do you take or have you taken Phen-Fen or Redux? Yes No

Do you smoke or chew tobacco? Yes No

Do you use alcohol, cocaine, or other drugs? Yes No

Are you on a special diet? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you use more than two pillows to sleep? Yes No

Have you ever had any excessive bleeding requiring special treatment? Yes No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No

Have you been treated in a hospital in the last five years? Yes No

If female, please mark if you are:

Pregnant - If so, please enter your due date or week #:

Trying to get pregnant Nursing On birth control

Please list all current prescriptions:

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:

Reviewed by: Title: Date: / /