GWEN JORDEN, D.D.S.

COSMETIC & FAMILY DENTISTRY

PATIENT INFORMATION: Today's Date ___/___/___

Name _____ DOB ___/___/___ Sex ____ Married/ Single _____

Address _____City, State & Zip _____

Social Security # _____ Driver's License # _____

E-mail Addres: _____

Home Phone _____ Work Phone _____ Cell Phone _____

How did you hear about our office? _____

Patient's Employer _____

Address _____ City, State, & Zip _____

Phone _____ Department/Ext. _____ Employed since _____

Primary Care Physician _____ Date last seen _____

Preferred Pharmacy _____ Phone (if known) _____

Last seen hear (year) _____ Reason for today's visit _____

If you are a full time student, please list school you attend _____

GUARANTOR/SUBSCRIBER INFORMATION (Financially Responsible Party)

Name _____ Date of Birth _____

Address _____City, State, & Zip _____

Employer _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

EMERGENCY CONTACT INFORMATION

Relative or friend for emergency contact _____ Phone# _____

NOTE: We require a minimum of 24 hours notice for appointment changes. A $35.00 charge will be applied for broken or missed appointments without advanced notice being given to the office. **PLEASE INITIAL THIS HERE** _____

PLEASE COMPLETE HEALTH HISTORY & INSURANCE INFORMATION ON REVERSE SIDE

5301 50TH suite 300 • Lubbock, Texas 79414
Office: (806)797-7078 • Fax: (806)792-3739
Email at: gwenjorde@suddenlink.net

HEALTH HISTORY

Check any of the following that apply to you:

___ Cancer	___ Epilepsy	___ Heart Murmur
___ Anemia	___ Artificial Joints	___ Mitral Valve Prolapse
___ Diabetes	___ Tuberculosis	___ Aids/ V.D./S.T.D.
___ Arthritis	___ Thyroid Problems	___ Rheumatic Fever
___ Headaches	___ Asthma/Sinus	___ Abnormal Bleeding
___ High Blood Pressure	___ Low Blood Pressure	___ Psychiatric Treatment
___ Hepatitis	___ Sleep Problems	___ Persistent Cough
___ Latex Allergy	___ Breast Augmentation	___ Bloody Cough
___ X-ray Therapy	___ Glaucoma	___ Fever
___ Night Sweats	___ Auto Immune Disorder	___ Mental Impairment
___ Development Disorder	___ Bone Density Drugs	___ Recreational Drugs

List any surgeries or hospitalizations in the last three years:

List any medications you are allergic to: _____

List any prescription medications you are taking:

_____

_____

Are you pregnant now? _____ # of Months _____ OB/GYN Dr. _____
Experienced any problems with anesthetics before? _____ Other problems _____

DENTAL INSURANCE

Primary Carrier _____ Address _____

Policy/Group # _____ Phone _____

Secondary Carrier _____ Address _____

Policy/Group # _____ Phone _____

** NOTICE**

If you plan to utilize dental insurance by assigning your benefits to this office, you will be expected to pay the estimated patient portion that your insurance will not pay at the time of service. You agree to be responsible for any amount not paid by your dental insurance company.

Payment today will be: ___ Cash/Check ___ Mastercard/Visa ___ Care Credit

___ American Express ___ Discover Card

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, delinquency at the annual rate of 18% will become due on delinquent accounts.

Signature _____ Date _____