John R. Linstrom DDS PC
1605 E. Barnett Rd. Medford, OR 97504

PATIENT INFORMATION

Patient's Name _____ (Last / First / Middle)
Preferred Name _____ Sex _____ Date of Birth _____
Address _____ (Street / City / State / Zip)
Home Phone _____ Cell Phone _____ Work Phone _____
Social Security #_____ Marital Status _____ Email address _____
Employer _____ Occupation _____ No. Years Employed _____
How did you learn about our office? _____

☐ Check box if same as above

Responsible Party Information

Name _____ (Last / First / Middle)
Address _____ (Street / City / State / Zip)
Home Phone _____ Cell Phone _____ Work Phone _____
Social Security # _____ Date of Birth _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____ Phone _____

Billing Information

Primary Dental Insurance

☐None ☐Self ☐Spouse ☐Mother ☐Father

Subscriber name _____
Date of Birth _____
Employer _____
Insurance Co. _____
Insured Social Security # _____
Insured Member ID # _____
Group # _____

Secondary Dental Insurance

☐None ☐Self ☐Spouse ☐Mother ☐Father

Subscriber name _____
Date of Birth _____
Employer _____
Insurance Co. _____
Insured Social Security # _____
Insured Member ID # _____
Group # _____

I understand I am financially responsible for all treatment charges whether or not paid by my insurance. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. If your insurance has not paid the expected percentage of your bill after 60 days, you must pay the outstanding balance within 30 days of receiving the monthly account statement. I hereby authorize the insurance dental benefits payable to me to be paid directly to John R. Linstrom DDS PC.

Responsible Party's Signature _____ Date _____

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MEDICAL HISTORY

Patient's Name _____ Date _____

Personal Physician Name _____ Physician Phone _____

Physician Address _____

Circle a definite answer for each question:

Yes No Have you been hospitalized within the past two years? For what?

_____

_____

Yes No Are you currently being treated by a physician? For what?

_____

_____

Yes No Have you been advised by a physician of the need for any type of surgery or treatment? What?

_____

Do you have, have you had, or been treated for any of the following?

Yes	No	HEART PROBLEMS	Yes	No	GLAUCOMA
Yes	No	RHEUMATIC FEVER	Yes	No	DIABETES
Yes	No	HEART MURMUR	Yes	No	KIDNEY DISORDER
Yes	No	MITRAL VALVE PROLAPSE	Yes	No	SHUNTS OR STENTS
Yes	No	HEART VALVE REPLACEMENT	Yes	No	HEPATITIS A:___ B:___ C:___
Yes	No	PACEMAKER TYPE	Yes	No	TUBERCULOSIS
Yes	No	HIGH BLOOD PRESSURE	Yes	No	HERPETIC COLD SORES
Yes	No	LOW BLOOD PRESSURE	Yes	No	ULCERS
Yes	No	ANEURYSM	Yes	No	THYROID CONDITION
Yes	No	HIP OR JOINT REPLACEMENT	Yes	No	MALIGNANT HYPOTHERMIA
Yes	No	ANOREXIA, BULIMIA	Yes	No	ARTHRITIS
Yes	No	CHEMICAL DEPENDENCY	Yes	No	ASTHMA
Yes	No	ANEMIA	Yes	No	CHRONIC SINUS OR EAR INFECTIONS
Yes	No	HEMOPLILIA, BLOOD DISORDER	Yes	No	RADIATION OR CHEMICAL THERAPY
			Yes	No	EPILEPSY, SEIZURES

Yes No Are you currently taking any prescription drugs of any kind? If yes, which? _____

_____

Yes No Are you currently taking any non-prescription drugs of any kind? If yes, which? _____

_____

Yes No Are you allergic to any drugs? Which? _____

Yes No Have you ever experienced a skin reaction to jewelry or latex? Which? _____

Yes No Have you ever been told that you need to take antibiotics before dental treatment? Which? _____

Yes No Have you ever been tested for the HIV virus? If yes, what was the test: ❒ positive ❒ negative

Yes No Are you pregnant? Anticipated delivery date: _____

Yes No Do you use tobacco or alcohol products? Daily intake: _____

Yes No Have you ever experienced any unfavorable reactions to dental procedures? What?

_____

I certify the above to be true and correct to the best of my knowledge.

Patient or Guardian's Signature _____ Date _____

John R. Linstrom, D.D.S. P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

*Date:*_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____