Dr. Jason Ray, DDS - Family Dentistry

698 East 1st Street in Thibodaux, LA. Phone 985-446-8037

Welcome, and thank you for selecting us. To help us meet all your dental needs, please fill out this form. You can use Microsoft Word, or print it and fill it out completely in ink. If you have any questions or need assistance, please call us at 985-446-8037, and we will be happy to help.

Patient Information (Confidential) Please Complete The Shaded Areas.

	Patient Number:					
Name:		Date:				
SS# / SIN:	Birth date:	Home Phone:				
Address:		City:	State:	Zip Code:		
Email:			Cell Phone:			
Check Appropriate Box:	☐ Minor	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
If Student, Name of School/College:		City:	State:	☐ Full Time	☐ Part Time	
Patient or Parent/Guardian's Employer:			Work Phone:			
Business Address:		City:	State:	Zip Code:		
Spouse or Parent/Guardian's Name:		Employer:		Work Phone:		
Whom May We Thank for Referring You?						
Person to Contact in Case of Emergency:			Phone:			
Responsible Party						
Name of Person Responsible for this Account:			Relationship to Patient:			
Address:		City:	State:	Zip Code:		
Email:		Home Phone:	Cell Phone:			
Driver's License #:		Birth date:	Financial Institution:			
SS#/SIN:		Employer:	Work Phone:			
Is this Person Currently a Patient in our Office?	Yes ☐	No ☐				
For your Convenience, we offer the following methods of payment. Please check the option you prefer. <u>Payment in full at each appointment</u>						
☐ Cash	☐ Personal Check	☐ Credit Card	☐ Visa	☐ Master Card	☐ I wish to discuss the office's payment policy	

Insurance Information

Name of Insured:			Relationship to Patient:	
Birth Date:	SS#/SIN:		Date Employed:	
Name of Employer:	Union or Local #:		Work Phone:	
Employer Address:	City:	State:	Zip Code:	
Insurance Company:	Group #:		Policy/ID#:	
Ins. Co Address:	City:	State:	Zip Code:	
How Much is Your Deductible? $	How Much Have You Used? $		Max. Annual Benefit: $	
Do You Have Any Additional Insurance?	☐ Yes	☐ No	If Yes, Please Complete the Following	
Name of Insured:			Relationship to Patient:	
Birth date:	SS#/SIN:		Date Employed:	
Name of Employer:	Union or Local #:		Work Phone:	
Employer Address:	City:	State:	Zip Code:	
Insurance Company:	Group #:		Policy/ID#:	
Ins. Co. Address:	City:	State:	Zip Code:	
How Much is Your Deductible? $	How Much Have You Used? $		Max. Annual Benefit: $	

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

		Yes	No
1.	Are you under medical treatment now?	☐	☐
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ _____	☐	☐
3.	Are you taking and medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ (If you need additional space, use the bottom of page 3)	☐	☐
4.	Have you ever taken Fen-Phen/Redux?	☐	☐
5.	Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing biphosphonates?	☐	☐
6.	Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7.	Do you use tobacco?	☐	☐
8.	Do you use controlled substances?	☐	☐
9.	Do you have or have you had the following	☐	☐

		Yes	No
10.	Are you wearing contact lenses?	☐	☐
11.	**Are you allergic to or have you had any reactions to the following?**	☐	☐
	Local Anesthetics (e.g. Novocain)	☐	☐
	Penicillin or any other Antibiotics	☐	☐
	Sulfa Drugs	☐	☐
	Barbiturates	☐	☐
	Sedatives	☐	☐
	Iodine	☐	☐
	Aspirin	☐	☐
	Any Metals (e.g. nickel, mercury, etc.)	☐	☐
	Latex Rubber	☐	☐
	Codeine	☐	☐
	Other _____	☐	☐
12.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13.	**Women Only:**	☐	☐
	Are you pregnant or think you may be pregnant?	☐	☐
	Are you nursing?	☐	☐
	Are you taking oral contraceptives?	☐	☐

Do You Have	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/ Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Bruise Easily	☐	☐
Chemotherapy	☐	☐
Congenital Heart Disorder	☐	☐

Do You Have	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Excessive Bleeding	☐	☐
Excessive Thirst	☐	☐
Renal Dialysis	☐	☐

Do You Have	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapsed	☐	☐
Scarlet Fever	☐	☐
Shingles	☐	☐
Sickle Cell Disease	☐	☐
Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam _____

		Yes	No
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do you feel pain to any of your teeth?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck of jaw injuries?	☐	☐
7.	Have you experienced any of the following problems in your jaw?	☐	☐
	Clicking	☐	☐
	Pain (joint, ear, side of face)	☐	☐
	Difficulty in opening or closing	☐	☐
	Difficulty in chewing	☐	☐

		Yes	No
8.	Do you have frequent headaches?	☐	☐
9.	Do you clench or grind your teeth?	☐	☐
10.	Do you bite your lips or cheeks frequently?	☐	☐
11.	Have you ever had any difficult extractions in the past?	☐	☐
12.	Have you ever had any prolonged bleeding following extractions?	☐	☐
13.	Have you had any orthodontic treatment?	☐	☐
14.	Do you wear dentures or partials? If yes, date of placement:	☐	☐
15.	Have you ever received oral hygiene instructions?	☐	☐
16.	Do you like your smile?	☐	☐

(Continued from #3 on page 2) Please use this space to list any additional medications you are taking--including non-prescription medicine.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Jason R. Ray, DDS to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance	Company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Print Name Here: _____ X _____ Signature of patient (or parent/guardian if minor) (You can sign this form on your first visit to our clinic)

Doctor's Comments _____

_____

_____

Signature _____ Date _____

Please fill out the form, sign it and print it out. You can return this form at your first visit.

Or if you wish to email this form back to us as an attachment, use this email address.

Email the attached form to Dr. Jason Ray

*****By Providing us with your details, you agree to communicate with us via SMS, Email, or Call. You can opt-out anytime by notifying our Office*****