Jorgensen
Advanced Dental Center
Where Your Smile Matters™

140 Luring Dr, Suite A
Palm Springs, CA 92262
760-323-2771
office@jayjorgensendds.com

Dear New Patient,

We are happy that you have chosen our office! We look forward to meeting you at your first visit. Enclosed, you will find our new patient paperwork. We appreciate it if you would take the time to complete this before your first visit.

Dr. Jorgensen has been licensed in dentistry since receiving his Doctor of Dental Surgery (DDS) degree from UCLA School of Dentistry in 1993. As a graduate, he received honors from UCLA demonstrating outstanding skill in Operative Dentistry and Geriatric/Long Term Care. After completing extensive courses in Advanced Cosmetic Dentistry at Baylor College of Dentistry, he received his certificate in Advanced Aesthetic (Cosmetic) Dentistry in 1998. Over his 25 year career, Dr. Jorgensen has performed thousands of cosmetic, surgical and implant procedures, each one having individual and unique requirements. His experience has given him the skill and artistic ability to professionally and reliably create beautiful smiles transformations that enhance his patients lives.

Dr. Jorgensen has served terms as a Board Member for the Palm Springs Chamber of Commerce and the Desert Aids Project (DAP). He was the lead dental professional personally volunteering over 500 professional dental hours to enable the establishment of the DAP Dental Clinic, which opened in 2008. Dr. Jorgensen enjoys his family time with his son, Riley. They enjoy traveling, playing golf, tennis, skiing, scouting and other activities.

At Jorgensen Advance Dental Center, we pride ourselves in personalized high quality "comfort" care. We provide treatment outcomes that help our patients prioritizeand attain optimal dental health. We offer convenient hours, see emergencies after hours and accept most insurance plans. To improve your overall dental experience, we employ special procedures for anyone who may have dental anxiety or fear. Our desire is that you have comfortable dental visits and are confident in the care you receive. Thank you for placing your trust and confidence in our dental team. We welcome you as part of our practice family.

Warm regards,

Dr. Jay Jorgensen and Staff

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Patient Registration

Please complete the following confidential registration information

Patient / Guardian if not patient

Date:

Last Name: First M.I.

Prefers to be called by:

Address

City State CA Zip

Home Phone Fax

Cell EMail

Birthdate Age Male Female

Married Single Divorced Widowed

Social Security No.

Patient Information if Dependent

Date:

Last Name: First M.I.

Prefers to be called by:

Address

City State CA Zip

Home Phone Fax

Cell EMail

Birthdate Age Male Female

Married Single Divorced Widowed

Social Security No.

Dental Insurance / Primary

Insurance Company

Group No Insured DOB

Relationship to Patient Other Relationship Insured's I.D. No.

Insured Name

Employer Name

Insured Social Security No

Dental Insurance / Secondary

Insurance Company

Group No Insured DOB

Relationship to Patient Other Relationship Insured's I.D. No.

Insured Name

Employer Name

Insured Social Security No

Account Information

Person Financially Responsible for account

Name

Relationship to patient Other Relationship Social Security No

Address

City State CA Zip

Phone No

General Information

Is another member of your family or relative a patient at our office?

Name:

Relationship Other Relationship

Who referred you to us:

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Patient Registration

Consent for treatment

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient's Signature _____ Date_____ Witness_____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

Person to contact in case of Emergency

Last Name:		First		M.I.	
Home Phone		Cell			
Address					
City		State	CA	Zip	

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Health History Form

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water? DAILY / WEEKLY / OCCASIONALLY			
Have you ever whitened your teeth?			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

If you could change anything about your smile, what would it be?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: Include ar ea code

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, aledronate (Foamax) or risedronate (Actonel) for osteoporosis or Paget's?	☐	☐	☐

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all medications you are currently taking, including vitamins, natural or herbal preparations and/or diet supplements:

Allergies - Are you allergic to or have you had a reaction to any of the following:
To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐

	Yes	No	DK
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:			
Recurrent Infections	☐	☐	☐
Type of infection:			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger, shoulder) replacement? ☐ ☐ ☐

Date:_____ If yes, Have you had any complications? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐

Number of weeks: _____

Taking birth control pills or hormonal replacement? ☐ ☐ ☐

Nursing? ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST

Comments:_____