

Thank you for choosing our office. Because we care, we want to find out as much information as possible so we can render accurate treatment. Please fill out this confidential form completely. Thank You.

**Patient Info:**

**Today's date:** \_\_\_\_\_

Male

Female

Birth date \_\_\_\_\_ Age \_\_\_\_\_

E-mail \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Nickname \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Single

Divorced

Married Spouse Name \_\_\_\_\_

Widowed

**Responsible Party:** (For decision making if the patient is underage & also for payment)

(If different than patient listed above)

Relationship to patient \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Suffix \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security \_\_\_\_\_ E-mail \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Married

Spouse Name \_\_\_\_\_

Divorced

(Only need info below if patient is a Dependent)

Other Responsible Party Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Dental Insurance:**

Primary Insurance

No Dental Insurance

Secondary Insurance

Ins. Co. _____ Ins. Phone _____ Name of Insured _____ Relationship to patient _____ SS# _____ DOB _____ ID # _____ Group # _____ Employer _____ Employer Phone _____	Ins. Co. _____ Ins. Phone _____ Name of Insured _____ Relationship to patient _____ SS# _____ DOB _____ ID # _____ Group # _____ Employer _____ Employer Phone _____
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**Getting to know you:**

How did you hear about us?

I am an existing patient

Sign

Insurance

Phone Book

Newspaper

Website

AT & T-Yellow Pages

Yellow Book-Yellow Pages

Impact-Small Local Book

Did someone refer you to our office?  No  Yes Who can we thank? \_\_\_\_\_

Do we treat a family member?  No  Yes Who? \_\_\_\_\_

~Please continue on reverse side~

**Dental History:**

Your last dental visit was \_\_\_\_\_ Last complete exam was \_\_\_\_\_ Was treatment completed? No Yes

Previous Dentist \_\_\_\_\_ Where? \_\_\_\_\_

My last x-rays were taken \_\_\_\_\_ May we contact them for your dental records? No Yes

**Your Mouth:**

What is the major reason you seek care at this time? \_\_\_\_\_

- Exam/Cleaning Pain Cosmetic Missing Teeth Infection
- Broken Teeth Dentures Color Bad Taste/Odor Orthodontics

Would you like to improve your smile? No Yes How? \_\_\_\_\_

How are your gums? Seem healthy Bleed occasionally Bleed Often Swollen

How is your ability to chew? Fine Limited Needs help

How are your teeth? Seldom hurt Sensitivity to hot/cold Pain to sweets Pain to chew

How is your jaw? Pops/clicks when moving Has locked open/shut Causes pain

**\*\*\*I understand that patient names will be posted in our appointment books, on charts, and on schedules posted in treatment areas of the office and that patient privacy will be maintained as much as possible. I also understand that the staff of Eureka Smile Center may take photos of treatment that may be used in educational settings and professional teaching.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Medical History:**

**Females only**

- I am pregnant, may be, or am attempting to become so. Today's date: \_\_\_\_\_
- How many weeks pregnant are you? \_\_\_\_\_ Physician \_\_\_\_\_

*\*NOTE: Some medications may cause changes in birth control or may affect the unborn baby.*

**All Patients**

Please check all that you have or have had in the past:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart Murmur (Mitral Valve Prolapse) | <input type="checkbox"/> Venereal Disease          | <input type="checkbox"/> Allergies              |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Psychiatric Care          | <input type="checkbox"/> Alzheimer's            |
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Angina                 |
| <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Sore/Enlarged Lymph Nodes | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Hepatitis, all types                 | <input type="checkbox"/> Previous Biopsies         | <input type="checkbox"/> Blood Disease          |
| <input type="checkbox"/> Rheumatic Fever                      | <input type="checkbox"/> Joint Replacement         | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Chemotherapy           |
| <input type="checkbox"/> AIDS/HIV positive                    | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Chest Pains            |
| <input type="checkbox"/> Emphysema                            | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Parathyroid Disease    |
| <input type="checkbox"/> Congenital Heart Disease             | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Lung Disease           |
| <input type="checkbox"/> Kidney Disease                       | <input type="checkbox"/> Latex Sensitivity         | <input type="checkbox"/> Pain in Jaw Joints     |
| <input type="checkbox"/> Heart Attack year? _____             | <input type="checkbox"/> Stroke year? _____        | <input type="checkbox"/> Thyroid Disease        |
| <input type="checkbox"/> Heart Pace Maker                     | <input type="checkbox"/> Previous Endocarditis     | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Heart Transplant                     | <input type="checkbox"/> High Blood Pressure       |   |

Comments or any other illness we should know: \_\_\_\_\_

Do you consume a lot of grapefruit juice, grapefruits or grapefruit extract?  No  Yes

List of Current Medications: \_\_\_\_\_

**Allergies:** Have you had any allergies to any medications? No Yes

- Aspirin Penicillin Codeine Local Anesthetic Latex Metals

Explain any past allergies: \_\_\_\_\_

**By signing, I agree that the above information is correct & true.**

X \_\_\_\_\_

**Updates to History (Staff use only)**

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## HIPPA Privacy Notice Information

### Confidentiality Notice

*I, the patient or responsible party, understand all of the information provided to be accurately answered and I understand that it is my responsibility to notify Eureka Smile Center of changes in any of the above information. I also realize that all of this information that I have provided is confidential and that none of the information here will be released to anyone without permission from the patient. A more complete copy of your privacy rights are available upon request.*

*Signed* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signed* \_\_\_\_\_

*Parent/Legal guardian's signature if patient is under legal age*

### Dental Insurance Acknowledgement

*I understand that dental insurance is an agreement between myself, the employee, and the insurance company. Benefits change according to the plan between employee-employer-insurance company relationship and Eureka Smile Center can never be 100% sure of that coverage and/or benefits and are **NOT** responsible for them. Estimates may be made according to what the insurance representative provides. **The patient or responsible party is ultimately responsible for all fees not covered by insurance.***

*In the case of minors of separated or divorced parents, it is the responsibility of the parent bringing the patient into the office to arrange appointments and keep treatment and all accounts current.*

*Signed* \_\_\_\_\_ *Date* \_\_\_\_\_

*(patient or responsible party)*

