



Welcome to Eastland Dental Center

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Male Female

Birth Date: ___/___/___ Age: _____ Social Security #: _____

Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: _____ Cell/other #: _____ Work Phone #: _____ Ext: _____ Driver's License #: _____

Where and when are the best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation : _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

Name: _____ Relation: _____ Work Phone #: _____ Home Phone #: _____

Address: _____
Street City State Zip

SPOUSE INFORMATION

Name: _____ Birth Date: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext: _____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Member ID #: _____ Insured's Birth Date: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Member ID #: _____ Insured's Birth Date: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

DENTAL HISTORY

Why have you come to the dentist today: _____

- Are you currently in pain? Yes No
- Do you require antibiotics before dental treatment? Yes No
- Your current dental health is Good Fair Poor
- Do you floss daily? Yes No Brush daily? Yes No
- Type of bristles on your toothbrush Hard Medium Soft
- Do your gums ever bleed? Yes No Ever Itch? Yes No
- Have you ever had periodontal disease? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

- Do you have mobility in your teeth? Yes No
- Do you still have wisdom teeth? Yes No
- Previous/Present Dentist: _____ Last Visit Date: _____
- Would you like fresher breath? Yes No Whiter teeth Yes No
- Straighter teeth Yes No
- Are you happy with the way your smile looks?** Yes No

If not, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____

Street

City

State

Zip

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Phen-Fen, Redux, or Pondimin? Yes No

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Do you or have you experienced the following?

- | | | | | |
|----------------------------|-------------------------------|---------------------------|---------------------------|--------------------------------|
| Y N AIDS/HIV Positive | Y N Cold Sores/Fever Blisters | Y N Glaucoma | Y N Leukemia | Y N Sickle Cell Disease |
| Y N Alzheimer's Disease | Y N Congenital Heart Disorder | Y N Hay Fever | Y N Liver Disease | Y N Sinus Trouble |
| Y N Anaphylaxis | Y N Convulsions | Y N Heart Attack/Failure | Y N Low Blood Pressure | Y N Spina Bifida |
| Y N Anemia | Y N Cortisone Medicine | Y N Heart Murmur | Y N Lung Disease | Y N Stomach/Intestinal Disease |
| Y N Angina | Y N Diabetes | Y N Heart Pacemaker | Y N Mitral Valve Prolapse | Y N Stroke |
| Y N Arthritis/Gout | Y N Drug Addiction | Y N Heart Trouble/Disease | Y N Osteoporosis | Y N Swelling of Limbs |
| Y N Artificial Heart Valve | Y N Easily Winded | Y N Hemophilia | Y N Pain in Jaw Joints | Y N Thyroid Disease |
| Y N Artificial Joint | Y N Emphysema | Y N Hepatitis A | Y N Parathyroid Disease | Y N Tonsillitis |
| Y N Asthma | Y N Epilepsy or Seizures | Y N Hepatitis B or C | Y N Psychiatric Care | Y N Tuberculosis |
| Y N Blood Disease | Y N Excessive Bleeding | Y N Herpes | Y N Radiation Treatments | Y N Tumors or Growths |
| Y N Blood Transfusion | Y N Excessive Thirst | Y N High Blood Pressure | Y N Recent Weight Loss | Y N Ulcers |
| Y N Breathing Problem | Y N Fainting Spells/Dizziness | Y N High Cholesterol | Y N Renal Dialysis | Y N Venereal Disease |
| Y N Bruise Easily | Y N Frequent Cough | Y N Hives or Rash | Y N Rheumatic Fever | Y N Yellow Jaundice |
| Y N Cancer | Y N Frequent Diarrhea | Y N Hypoglycemia | Y N Rheumatism | Y N Steroid Therapy |
| Y N Chemotherapy | Y N Frequent Headaches | Y N Irregular Heartbeat | Y N Scarlet Fever | Y N Snoring/Sleep Apnea |
| Y N Chest Pains | Y N Genital Herpes | Y N Kidney Problems | Y N Shingles | |

Please list any serious medical conditions that you have experienced: _____

Are you taking any prescription/over-the-counter drugs? Yes No If yes, please list each one: _____

Are you allergic to any of the following?

- | | | | | | |
|------------------|------------------------|--------------------|----------------|-----------------|------------------|
| Y N Aspirin | Y N Codeine | Y N Erythromycin | Y N Latex | Y N Sedatives | Y N Tetracycline |
| Y N Barbiturates | Y N Dental Anesthetics | Y N Jewelry/Metals | Y N Penicillin | Y N Sulfa Drugs | Y N Other |

Please list anything additional that causes allergic reactions: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, and deductible, and co-payment that my insurance does not cover. I have received a copy of the offices Notice of Privacy Practices.

Signature _____

Date _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____

Signature _____

Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____

Signature _____

Date _____