



Today's Date _____

Patient Information

Name: _____ Date of Birth: _____
Last First MI

Sex: M F Nickname: _____

Occupation: _____ Relationship Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Is this a cell phone? YES NO

Preferred method of contact (select all that apply): Phone Call Text E-mail

E-mail Address: _____

Social Security Number: _____

How did you hear about our practice? _____

Insurance Information

Name of Insurance: _____

Name of Insured Person: _____ Date of Birth: _____

Member ID # _____ Group # _____

Employer of Primary Insured Person: _____

Employer Address: _____

Emergency Contact

Relationship: _____ Phone Number: _____

Medical History

Are You Under the Care of a Physician? YES NO If YES, why? _____

Physician Name: _____ Phone Number: _____

When was your last Medical Exam? _____

Has there been a change in your general health in the last year? YES NO

If yes, what condition is being treated? _____

Have you ever had an operation or been hospitalized? YES NO

If Yes, what was the illness or problem? _____

Do you have a History of:

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Hip/Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Neck/Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
HPV	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Do you have any diseases or serious illness you think we should know about/not listed?

Are you taking or have recently taken any prescription or over the counter medication(s)? YES NO

If so please list all, including vitamins, natural or herbal supplements and/or diet supplements:

Are you taking or have you ever taken bisphosphonates? _____
 (Fosamax or Actonel for osteoporosis, chemotherapy, etc)

Are you on an anticoagulant replacement? (blood thinner or aspirin therapy) _____

If yes, What medication? _____

Are you allergic to any medications? YES NO If YES please list below:

Do you Smoke or Chew Tobacco? _____ Frequency? _____

FOR WOMEN ONLY:

Are you taking birth control pills? YES NO Are you nursing/breastfeeding? YES NO

Are you pregnant? YES NO Expected delivery date: _____

Is there a possibility of pregnancy? YES NO

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of birth control.

Dental History information

Date of last dental visit? _____

Reason for today's visit? _____

Name of your previous dentist _____

Have you ever had an oral cancer screening? YES NO

How often do you Floss your teeth? _____

Do your gums bleed when you brush? YES NO

Have you or a family member ever been treated for periodontal disease? YES NO

Have you ever had complications from an extraction? YES NO

Have you ever had a popping or clicking near your ear when you chew? YES NO

Are you prone to frequent headaches? YES NO

Do you grind or clench your teeth? YES NO

Do you have sores, blisters or swelling on your gums lips or cheeks? YES NO

Have you ever had orthodontic treatment? YES NO

Do you snore? YES NO

Do you ever feel tired during the day? YES NO

Do you have problems with bad breath? YES NO

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? YES NO

Have you ever used an electric toothbrush? YES NO

Are your teeth sensitive to hot, cold or pressure? YES NO

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- Whiter
- Straighter
- Close space
- Replace black mercury filling with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Less gums showing
- Replace old crowns or caps that don't match
- Other: _____

What is your primary concern you would like us to address today?

PAYMENT POLICY, HIPAA POLICY, and PHOTO RELEASE

NAME OF PATIENT: _____ (“patient”)

Payment Agreement:

- I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me.
- I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to \$35.00, but not to exceed the maximum amount permitted by law for each returned check.
- I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney’s fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Patient Photo Release Form

I _____, hereby authorize Easton Dental Studio or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (First name only) could be used unless stated differently below. I do not expect compensation, Financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing. If declining this consent, leave blank.

Please initial one option:

- I agree to the above conditions.
- I only agree to have my teeth shown without any identifying features.
- I agree to ONLY have photographs taken for treatment planning purposes only.

By signing you agree to Easton Dental Studio’s payment policy. You also certify that you have read a copy of Easton Dental Studio’s Notice of Privacy Practices. If you would like a copy of our policy please see our staff. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Signed _____ Date _____