EASTON DENTAL STUDIO

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	☐	☐	Chemical Dependency	☐	☐	Head injuries	☐	☐
Alcoholism	☐	☐	Chest Pain	☐	☐	Hearing Impaired	☐	☐
Allergies	☐	☐	Circulatory Problems	☐	☐	Heart Disease	☐	☐
Anemia	☐	☐	Convulsions/Seizures	☐	☐	Heart Murmur	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐
Blood Disease	☐	☐	Epilepsy	☐	☐	Hepatitis Carrier	☐	☐
Bone Disease	☐	☐	Glaucoma	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	Hay fever	☐	☐	Hip/Joint replacement	☐	☐
Jaundice	☐	☐	Nervous Disorders	☐	☐	Fainting spells	☐	☐
Kidney Disease	☐	☐	Pacemaker	☐	☐	Sinus Problems	☐	☐
Kidney Dialysis	☐	☐	Prosthetic Joints	☐	☐	Stomach Ulcers	☐	☐
Latex Sensitivity	☐	☐	Psychiatric Care	☐	☐	Stroke	☐	☐
Lupus	☐	☐	Radiation Treatment	☐	☐	Thyroid Disease	☐	☐
Low Blood Pressure	☐	☐	Respiratory Disorder	☐	☐	Tuberculosis	☐	☐
Malignancies	☐	☐	Rheumatic Fever	☐	☐	Tumors or growths	☐	☐
Mitral Valve Prolapse	☐	☐	Rheumatism	☐	☐	Ulcers	☐	☐
Neck/Back Problems	☐	☐	Scarlet Fever	☐	☐	Venereal Disease	☐	☐
HPV	☐	☐	Seizures	☐	☐		☐	☐

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 Pile 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 benePits 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 (Pirst name only) could be used unless stated differently below. I do not expect compensation, Pinancial 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 ofPice your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Do we have your consent to send you text message appointment reminders, statements, or invites to leave a review on Google? If yes, you may opt out at any time. ☐ Yes ☐ No

Signed ______________________________ Date ______________