Patient Information

Full Name: ____ Preferred Name: ____________________

Address: ____________________________City:__________________ State:_______ Zip Code:___________

Home#: ______________________ Work#: ______________________ Cell#: __________________________

Sex: ______ Male _______Female Marital Status: _____ Married _____Single ______Other

Date of Birth: ___________________ SSN: _____________________ Driver's License: ______________________

Email: ___________________________________ Employment: ____Full-Time ____Part-Time ____Retired

Employer Name/City & State: ____

Student: ____ Full-Time ____Part-Time ___Non School Name/City & State: _________________________

Emergency Contact Name & Phone Number:

____#_____________________________________

How did you hear about our dental practice? ____

Responsible Party (if other than patient)

Full Name: ____ Relationship to Patient: _________________

Address: ____

Home#: ______________________ Work#: _______________________ Cell#: __________________________

Sex: _______ Male _______Female Marital Status: _______ Married _______Single

Date of Birth: ___________________ SSN: _____________________ Driver's License: ______________________

Primary Dental Insurance Information

Insurance Name: _________________________________ Policy # ______________________________________

Member ID #______________________Group#: ______________________ Plan: ________________________

Policy Holder's Name: ______________________________ Policy Holder's SSN: ___________________________

Relationship to Patient: _____Self _____ Spouse _____Parent Policy Holder's DOB: _____________________

Employer (if employer sponsored): ____

Secondary Dental Insurance Information

Insurance Name: _________________________________ Policy # ______________________________________

Member ID #______________________Group#: ______________________ Plan: ________________________

Policy Holder's Name: ______________________________ Policy Holder's SSN: ___________________________

Relationship to Patient: _____Self _____Spouse _____Parent Policy Holder's DOB: _____________________

Employer (if employer sponsored): ____

MEDICAL HISTORY

Name: ____

Are you under a physician's care now? ( ) Yes ( ) No
If yes, name & number____

Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No
If yes, please list____

Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? ( ) Yes ( ) No
If yes, please list____

Do you use tobacco or Vape? ( ) Yes ( ) No If yes, please answer the following:
Type___________________ Packs per day________ Years of use________ Quit date_____________________

Are you allergic to any of the following? ( ) Yes ( ) No
( ) Aspirin ( ) Penicillin ( ) Metal ( ) Latex ( ) Adhesives ( ) Sulfa ( )Codeine
If other, please list____

Do you use any controlled substances? ( ) Yes ( ) No
If yes, please list____

Women only: Please check if you are any of the following:
( ) Pregnant/Trying to get pregnant ( ) Nursing ( ) Taking oral contraceptives

Do you have, or have you had, any of the following? (If yes, please check.)

( ) Alzheimer's Disease
( ) Anaphylaxis
( ) Anemia
( ) Angina/Chest Pains
( ) Arthritis/Gout
( ) Artificial Heart Valve
( ) Artificial Joint
( ) Asthma
( ) Blood Disease
( ) Breathing Problems
( ) Bruise Easily
( ) Cancer
( ) COPD/Winded Easily
( ) Chemotherapy
( ) Cold Sores/Fever Blisters
( ) Congenital Heart Disorder
( ) Convulsions
( ) Pain in jaw joints
( ) Radiation Treatments
( ) Rheumatic Fever
( ) Shingles
( ) Spina Bifida
( ) Swelling of limbs
( ) Tuberculosis
( ) Sleep Apnea/Snoring
( ) Diabetes
( ) Drug Addiction
( ) Emphysema
( ) Epilepsy/Seizures
( ) Excessive Bleeding
( ) Excessive Thirst
( ) Fainting Spells/Dizziness
( ) Frequent Cough
( ) Frequent Diarrhea
( ) Frequent Headaches
( ) Glaucoma
( ) Hay Fever/Allergies
( ) Heart Attack/Failure
( ) Hypoglycemia
( ) Heart Murmur
( ) Heart Pace Make
( ) Heart Disease
( ) Parathyroid Disease
( ) Recent weight loss/gain
( ) Rheumatism
( ) Sickle Cell Disease
( ) Stomach/Intestinal Disease
( ) Thyroid Disease
( ) Tumors or Growths
( ) Tobacco use or Vaping
( ) Hemophilia
( ) Hepatitis A, B or C
( ) Herpes
( ) HIV Positive/AIDS
( ) High Blood Pressure
( ) High Cholesterol
( ) Hives/Rash
( ) Irregular Heart Beat
( ) Kidney Problems
( ) Leukemia
( ) Liver Disease
( ) Low Blood Pressure
( ) Lung Disease
( ) PRE-MEDICATION
( ) Mitral Valve Prolapse
( ) Osteoporosis
( ) Hernia Repair
( ) Psychiatric Disorder
( ) Renal Dialysis
( ) Sexually Transmitted Disease
( ) Sinus Trouble
( ) Stroke
( ) Tonsillitis
( ) Ulcers
( ) Other ______________________

MEDICAL HISTORY (cont.) Name: ____

Are you currently taking any blood thinners (Aspirin, Coumadin, Warfarin, Plavix, etc)?
( ) Yes ( ) No If yes, please list____

Please list all MEDICATIONS you are currently taking including dietary supplements, herbal medicines and natural products:

NAME	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

DENTAL HISTORY

Reason for seeking dental care ____

Date of last dental visit ___________________________ **Date of last X-rays**_______________________________

How often do you: Brush ______times per _____________ Floss ______ times per _______________

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following?

____Aching/sensitive teeth
____Persistent bleeding gums
____Broken/missing/loose teeth
____Grinding or clenching
____Swelling/lumps in mouth
____Growths/lesions in mouth
____Orthodontic treatment
____Broken/missing filling
____Loose teeth
____Bad breath
____Dry mouth
____Injuries to teeth/jaw
____Cold sores
____Other____
____Areas of food traps
____Difficulty opening wide
____Clicking or popping jaw
____Jaw pain or tiredness
____Gum infection
____Unfavorable dental experience

If you could change your smile, what would you change?

____Remove unsightly fillings ____Straighten teeth ____Change shape of teeth
____Close gaps between teeth ____Replace missing teeth ____Whitening
____Other____

Consents, Authorizations & Releases

I hereby certify that all information submitted is true and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform Eastern Pines Dental of any changes in my medical status.

I hereby agree to allow Eastern Pines Dental, it's Dentists and staff to take radiographs, study models, photographs or any other diagnostic aid he/she deems appropriate to make a thorough diagnosis of my dental needs and to perform any and all forms of dental treatment I have agreed upon.

I hereby authorize the release of information, including but not limited to, the diagnosis, radiographs and records of any treatments or examinations rendered by Eastern Pines Dental to my insurance company, insurance claims processing companies and consulting professionals associated with my treatment.

I hereby acknowledge that I am personally responsible for payment of all fees for dental services provided in this office for me and/or my dependents regardless of insurance coverage. I am aware that it is my responsibility to understand my own dental insurance policy including benefits, limitations and exclusions. I understand that the filing of insurance dental claims is provided as a courtesy and that any dental coverage is an agreement between my insurance company and myself. I understand that full payment or an estimated portion according to expected insurance coverage is due at time of service. This estimated portion may not be disclosed nor guaranteed by my insurance company, and I understand my portion may be more if my insurance company does not pay the anticipated estimated amount. I also understand that services are treatment planned and rendered independent of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related collection fees accrued.

I, the undersigned, understand that Eastern Pines Dental sets aside a dedicated chair and time slot for each patient scheduled. Cancelled/missed appointments prevent other patients needing services from being seen during that time. I understand and agree to the following appointment cancellation policies.

Please Initial each below:

________Appointments scheduled with any Dentist or hygienist must be cancelled/rescheduled at least 24 hours in advance to avoid the possible loss of the reservation deposit and/or a $50 cancelation fee.

________No-show appointments with any Dentist or hygienist will result in an automatic loss of the reservation deposit and/or a $75 cancelation fee.

________Repeated cancelled/missed appointments will result in loss of future appointment privileges.

I hereby acknowledge that by signing this consent I agree to adhere to the above policies.

X

Patient/Authorized Party Signature　　Printed Name　　Relationship　　Date

Acknowledgement of Receipt of Notice of Privacy Practices

Name: ____ **DOB:** _________________________________

Address: ____

Best # to reach you during the day: (____)___________________ **or** (____)_____________________

Email Address: ____

I give my permission for Eastern Pines Dental to discuss the selected items with the following offices/persons below:

Name(s) & Number(s) of those we may speak with (such as family members or friends)

Name____________________________________#_______________________________________

Relationship ______________________

CIRCLE ONE FOR EACH BELOW:

Confirming Appointments/Treatment – Yes No

Financial – Yes No

Medical/Dental History – Yes No

I have received a copy of the Notice of Privacy Practices for Marcus Brian Ward, DMD, PA dba Eastern Pines Dental.

x
____

Signature **Relationship** **Date**