

EUBANK FAMILY DENTISTRY, LLC

PATIENT MEDICAL HISTORY

DATE _____

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointments, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

NOTE: If patient is a minor, write name and relationship of responsible adult - address and occupation will pertain to responsible adult.

Patient name _____ Sex: M F
LAST FIRST MIDDLE

Mailing Address _____
STREET CITY STATE ZIP

Physical Address (if different from Mailing) _____

Email Address _____

Home Phone _____ Business Phone _____ Employer _____ Occupation _____

Date of Birth _____ Marital Status _____ Spouse's Name _____ Parents Names _____

Physician's name, address & phone _____

1. Date of last physical examination _____
2. Are you under any medical treatment now? If so, what?..... yes no
3. Have you had any major operations? If so, what?..... yes no
4. Have you had abnormal bleeding after cuts, surgery, or dental extractions?..... yes no
5. Have you ever required a blood transfusion?..... yes no
6. Have you had treatment for a tumor, growth, or other condition?..... yes no
7. Do you use tobacco?..... yes no
Pipe _____ Cigars _____ Snuff _____ Chewing Tobacco _____ Cigarettes _____ Packs per day _____

8. Do you have or have you ever had:
- | | | |
|--|---|--|
| <input type="checkbox"/> yes <input type="checkbox"/> no rheumatic fever | <input type="checkbox"/> yes <input type="checkbox"/> no sinus trouble | <input type="checkbox"/> yes <input type="checkbox"/> no hemophilia |
| <input type="checkbox"/> yes <input type="checkbox"/> no rheumatic heart disease | <input type="checkbox"/> yes <input type="checkbox"/> no epilepsy or seizures | <input type="checkbox"/> yes <input type="checkbox"/> no arthritis |
| <input type="checkbox"/> yes <input type="checkbox"/> no heart murmur | <input type="checkbox"/> yes <input type="checkbox"/> no fainting spells | <input type="checkbox"/> yes <input type="checkbox"/> no herpes |
| <input type="checkbox"/> yes <input type="checkbox"/> no heart attack | <input type="checkbox"/> yes <input type="checkbox"/> no liver disease | <input type="checkbox"/> yes <input type="checkbox"/> no stomach or intestinal problem |
| <input type="checkbox"/> yes <input type="checkbox"/> no stroke | <input type="checkbox"/> yes <input type="checkbox"/> no hepatitis or yellow jaundice | <input type="checkbox"/> yes <input type="checkbox"/> no stomach ulcer |
| <input type="checkbox"/> yes <input type="checkbox"/> no artificial heart valve | <input type="checkbox"/> yes <input type="checkbox"/> no kidney disease | <input type="checkbox"/> yes <input type="checkbox"/> no tumor or growth |
| <input type="checkbox"/> yes <input type="checkbox"/> no pacemaker | <input type="checkbox"/> yes <input type="checkbox"/> no steroid therapy | <input type="checkbox"/> yes <input type="checkbox"/> no thyroid problem or hormone deficiency |
| <input type="checkbox"/> yes <input type="checkbox"/> no high blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no AIDS, AIDS related condition | <input type="checkbox"/> yes <input type="checkbox"/> no glaucoma or other eye problems |
| <input type="checkbox"/> yes <input type="checkbox"/> no respiratory or lung disease | <input type="checkbox"/> yes <input type="checkbox"/> no or HIV positive | <input type="checkbox"/> yes <input type="checkbox"/> no implant/prosthesis |
| <input type="checkbox"/> yes <input type="checkbox"/> no tuberculosis | <input type="checkbox"/> yes <input type="checkbox"/> no anemia | <input type="checkbox"/> yes <input type="checkbox"/> no prosthetic joint replacement |
| <input type="checkbox"/> yes <input type="checkbox"/> no scarlet fever | <input type="checkbox"/> yes <input type="checkbox"/> no diabetes | |
| <input type="checkbox"/> yes <input type="checkbox"/> no asthma | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no emphysema | | |

9. Are you allergic to or have you ever reacted adversely to:
- yes no a. Local anesthetic (such as novocaine)
 - yes no b. Penicillin or other antibiotics
 - yes no c. Sulfa drugs
 - yes no d. Barbiturates, sedatives, or sleeping pills
 - yes no e. Aspirin
 - yes no f. Codeine
 - yes no g. Other _____

10. Are you taking any of the following:

- yes no a. Antibiotics or sulfa drugs
- yes no b. Anticoagulants (blood thinners)
- yes no c. Medicine for high blood pressure
- yes no d. Diuretics
- yes no e. Cortisone (steroids)
- yes no f. Tranquilizers
- yes no g. Antihistamines
- yes no h. Aspirin

- yes no i. Insulin
- yes no j. Thyroid medication
- yes no k. Digitalis
- yes no l. Nitroglycerin
- yes no m. Other drugs for heart condition
- yes no n. Weight control medicine
- yes no o. Immunosuppressants
- yes no p. Other

11. yes no Are you taking any over the counter or unprescribed medication? If so, please list:

WOMEN

- 12. yes no Are you pregnant?
- yes no Are you taking birth control pills?

PATIENT DENTAL HISTORY

- 1. What are your dental complaints at this time? _____
- 2. When was your last visit to a dentist? _____
- 3. Have you ever whitened (bleached) your teeth or would you be interested in whitening (bleaching) your teeth? _____
- 4. Do you have any concerns with bad breath? _____
- 5. Is there any condition or previous difficulty with dental treatment that your dentist should know about before undertaking treatment? If so, please explain: _____
- 6. Are you on well water? _____

REFERRAL: Whom may we thank for referring you to our office? _____

PAYMENT POLICY: In compliance with the Truth in Lending law, here is our credit policy: **It is customary to take care of fee at time service is rendered unless other arrangements have been made.** To assist you with this we accept VISA and MasterCard credit cards.

On reconstruction cases (crown and bridge, partial, and dentures) 50% of the fee is due at first appointment and balance at time of insertion.

If you have dental insurance, we will either assist you in filling out your insurance forms so that you can be reimbursed by your insurance company or we will accept assignment on that portion of charges covered by your insurance. When we accept insurance assignment, you are responsible for paying for any non-covered or deductible amounts at the time of treatment. In addition, you will be responsible for payment within 60 days for any additional charges filed which might be disallowed by your insurance company. Any unpaid balance will be subject to an additional fee if your account is turned over to a collection agency. An interest fee of 18% APR will be added to any balance over 60 days old. A fee of \$25.00 will be charged for returned checks.

My preferred method of payment is:

- Cash or Check at time of Visit MasterCard No. _____ VISA No. _____
- Dental Insurance Company _____ Policy No. _____

If Dental Insurance assignment is accepted, I authorize payment directly to Eubank Family Dentistry, LLC of any group insurance benefits otherwise payable to me and agree to the release of information relating to this claim. I certify that the medical and dental history information is correct to the best of my knowledge and that I have read and accept the above credit policy terms.

In accordance with the Patient Privacy Act, I acknowledge that I have read and understand Eubank Family Dentistry's Patient Privacy Notices in conjunction with the HIPAA Mandates.

Signature (parent or guardian if patient is a minor) Social Sec. # _____ Date _____