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) _____

Emergency Contact _____ Relationship _____ Phone _____

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

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4. Have you had abnormal bleeding after cuts, surgery, or dental extractions? ☐yes ☐no
5. Do you require antibiotics prior to dental treatment? ☐yes ☐no
6. Do you use tobacco? ☐yes ☐no

   Pipe _____ Cigars _____ Snuff _____ Chewing Tobacco _____ Cigarettes _____ Packs per day _____ Patches _____

7. Do you have or have you ever had:

☐yes ☐no rheumatic fever	☐yes ☐no sinus trouble	☐yes ☐no blood transfusion
☐yes ☐no rheumatic heart disease	☐yes ☐no epilepsy or seizures	☐yes ☐no hemophilia
☐yes ☐no **heart murmur**	☐yes ☐no fainting spells	☐yes ☐no arthritis
☐yes ☐no **heart attack**	☐yes ☐no liver disease	☐yes ☐no herpes
☐yes ☐no **stroke**	☐yes ☐no hepatitis or yellow jaundice	☐yes ☐no stomach or intestinal problem
☐yes ☐no **artificial heart valve**	☐yes ☐no kidney disease	☐yes ☐no stomach ulcer
☐yes ☐no **pacemaker**	☐yes ☐no steroid therapy	☐yes ☐no tumor or growth
☐yes ☐no high blood pressure	☐yes ☐no AIDS, AIDS related condition or HIV positive	☐yes ☐no thyroid problem or hormone deficiency
☐yes ☐no respiratory or lung disease		☐yes ☐no glaucoma or other eye problems
☐yes ☐no tuberculosis	☐yes ☐no anemia	☐yes ☐no **implant/prothesis**
☐yes ☐no scarlet fever	☐yes ☐no diabetes	☐yes ☐no **prosthetic joint replacement**
☐yes ☐no asthma		
☐yes ☐no emphysema		

8. 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. Latex Allergy
   - ☐yes ☐no h. Other _____

9. Sleep Apnea:
   - ☐yes ☐no Do you snore loudly?
   - ☐yes ☐no Are you moderately sleepy during waketime hours 3-4 times/week or more?
   - ☐yes ☐no Do you wake and still feel tired 3-4 or more times/week?
   - ☐yes ☐no Have you ever fallen asleep while driving?
   - ☐yes ☐no Do you awaken with a gasp for breath 3-4 times/week or more?
   - ☐yes ☐no Has anyone ever observed you stop breathing during your sleep?
   - ☐yes ☐no Do you grind your teeth?

-Over Please-

10. Please list all current medications:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Pharmacy Name: _____ City, State, Phone: _____

WOMEN

11. ☐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? _____

Do we have your permission to:

Leave a message on your answering machine at home? ____Yes ____No OR cell phone? ____Yes ____No

Leave a message at your place of employment? ____Yes ____No

Discuss your medical condition with any member of your household? ____Yes ____No

If yes, whom: _____ Relationship: _____

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 (crowns 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. A fee of $25.00 will be charged for returned checks.

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.

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