About You

Today's Date _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____ Cell _____

E-mail Address _____

SS No. _____

Date of Birth _____

Employer _____

Address _____

City _____

State _____ Zip _____

Work Phone _____

When & where is the best time to reach you _____

_____

Who may we thank for referring you _____

Any other family member we are seeing _____

_____

Approximate last time seen by a dentist and by whom

_____

About Your Spouse

Name _____

SS No. _____

Date of Birth _____

Employer _____

Address _____

City _____

State _____ Zip _____

Phone _____ Ext _____

Emergency

In the event of an emergency, who should we call?

Name _____

Relationship _____

Phone _____ Cell _____

Work Phone _____ Ext _____

Account Responsibility

☐ Check if same as patient

Name _____

Billing Address _____

City _____

State _____ Zip _____

Phone _____ Relationship _____

SS No. _____

Dental Insurance

Primary Dental Insurance

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____ Cell _____

Group No. _____

Local No. _____

Policyholder's Name _____

Policyholder's Employer _____

Employer's Address _____

City _____

State _____ Zip _____

SS No. _____ Date of Birth _____

Secondary Dental Insurance

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____ Cell _____

Group No. _____

Local No. _____

Policyholder's Name _____

Policyholder's Employer _____

Employer's Address _____

City _____

State _____ Zip _____

SS No. _____ Date of Birth _____

Time 3:25 PM | Crestwood Dental Group | Date 6/29/2018

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Payment Agreement

I agree to pay for all professional fees and treatment at the time of service, or my portion not covered by dental insurance, for myself, or above-named patient, unless other financial arrangements are approved. (A 1.5% monthly service charge will be assessed on all outstanding balances.) I also agree to pay for all costs of collection, including attorney fees and court costs, should additional means or collection be required. In addition, my signature on this form is my acknowledged authorization for the doctor to seek a credit report if credit is extended.

Signature _____

Date _____

Consent for Treatment

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____

Date _____