ecodental

Patient Information

Name_____ E-mail _____

Date of Birth _____/_____/_____ Sex: ❑M ❑F Social Security # _____ -_____-_____

Address_____City_____ State____ Zip Code_____

Home Phone __(_____)_____-_____ Cell Phone __(_____)_____-_____

Check appropriate box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient's Employer/School _____ Occupation _____

Work Phone __(_____)_____-_____ May we contact you at work? ❑Yes ❑No

Emergency Contact _____ Phone __(_____)_____-_____

Whom may we thank for referring you?_____

Parent/Guardian Information (if the patient is a minor)

Name_____ Relationship to patient _____

Date of Birth _____/_____/_____ Sex: ❑M ❑F Social Security # _____ -_____-_____

Address_____City_____ State____ Zip Code_____

Home Phone __(_____)_____-_____ Cell Phone __(_____)_____-_____

Dental Insurance Information

Name of Insured _____ Relationship to Patient_____

Subscriber's Date of Birth _____/_____/_____ ID/Social Security # _____

Name of Employer _____ Group No._____

Name of Dental Insurance Co. _____ Phone__(_____)_____-_____

Dental History

What is the reason for your visit today? _____

Previous Dentist's Name _____ Date of Last Dental Visit _____/_____/_____

How often do you brush? _____ How often do you floss? _____

Have you ever been told to take a pre-medication prior to dental treatment? ❑Yes ❑No

Please check any of the following that apply to you:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Broken Fillings
- ❑ Clicking or Popping Jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth
- ❑ Periodontal Disease
- ❑ Sensitivity to cold/hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Cold Sore/Fever Blisters

Medical History

Physician _____ Phone __(_____)_____-_____

Are you taking or have you recently taken any prescription or over the counter medicines? ❑Yes ❑No

If so, please list all, including vitamins _____

_____

Are you allergic to any of the following? ❑Aspirin ❑Penicillin ❑Codeine ❑Latex ❑Sulfa drugs

❑Other If yes, please list _____

Are you pregnant or planning a pregnancy? ❑Yes ❑No If yes, due date _____

Are you taking birth control pills? ❑Yes ❑No

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

AIDS/HIV Positive	○Yes ○No	Epilepsy or Seizures	○Yes ○No	Nervous Problems	○Yes ○No
Anaphylaxis	○Yes ○No	Excessive Bleeding	○Yes ○No	Osteoporosis	○Yes ○No
Anemia	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No	Psychiatric Care	○Yes ○No
Angina	○Yes ○No	Glaucoma	○Yes ○No	Radiation Treatments	○Yes ○No
Arthritis	○Yes ○No	Headaches/Migraines	○Yes ○No	Renal Dialysis	○Yes ○No
Artificial Heart Valve	○Yes ○No	Heart Murmur	○Yes ○No	Rheumatic Fever	○Yes ○No
Artificial Joint	○Yes ○No	Heart Pacemaker	○Yes ○No	Rheumatism	○Yes ○No
Asthma	○Yes ○No	Heart Disease	○Yes ○No	Scarlet Fever	○Yes ○No
Back Problems	○Yes ○No	Hemophilia	○Yes ○No	Shingles	○Yes ○No
Blood Disease	○Yes ○No	Hepatitis	○Yes ○No	Shortness of Breath	○Yes ○No
Breathing Problems	○Yes ○No	Herpes	○Yes ○No	Skin Rash	○Yes ○No
Cancer	○Yes ○No	High Blood Pressure	○Yes ○No	Sinus Trouble	○Yes ○No
Carpel Tunnel	○Yes ○No	High Cholesterol	○Yes ○No	Stomach Problems	○Yes ○No
Chemical Dependency	○Yes ○No	Hypoglycemia	○Yes ○No	Stroke	○Yes ○No
Chemotherapy	○Yes ○No	Jaw Pain	○Yes ○No	Swelling of Limbs	○Yes ○No
Chest Pains	○Yes ○No	Kidney Disease	○Yes ○No	Thyroid Disease	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	Leukemia	○Yes ○No	Tobacco Habit	○Yes ○No
Congenital Heart Disease	○Yes ○No	Liver Disease	○Yes ○No	Tonsillitis	○Yes ○No
Convulsions	○Yes ○No	Low Blood Pressure	○Yes ○No	Tuberculosis	○Yes ○No
Cortisone Treatments	○Yes ○No	Lung Disease	○Yes ○No	Tumors/Growths	○Yes ○No
Diabetes	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Ulcers	○Yes ○No

Please list any disease/conditions/problems not listed above _____

Authorization

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. By signing my signature, I have read and understand all of the above.

Signature:_____Date:_____