WELCOME to Eat Street Dental

Our goal is to help you reach and maintain maximum oral health and a happy, healthy smile. Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOU

Today's Date: _____

Name:_____

I prefer to be called (nickname):_____

Birthdate: ____/____/_____ Age: ____ ☐ Male ☐ Female

Occupation:_____ SS#:_____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Home Address:_____
Street Address Apt #

_____
City State Zip Code

Hm#:_____ Cell#:_____

Wk#:_____ Best time to reach you:_____

Preferred contact method: ☐Home ☐Cell ☐Work ☐Email

Email:_____

How did you hear about our practice? _____

Other family members seen by us: _____

2. RESPONSIBLE PARTY

(If patient is the responsible party, you do not have to fill this section out)

Name:_____

Relationship to Patient:_____

Billing Address:_____

_____

Hm#:_____ Cell#:_____

Wk#:_____ Best time to reach you:_____

Employer:_____ SS#:_____

3. INSURANCE

PRIMARY INSURANCE INFORMATION

Subscriber Name:_____ Birth Date:__/__/__

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Company Name:_____

Insurance Company Address:_____

Employer:_____

SS# or Group#:_____

SECONDARY INSURANCE INFORMATION

Subscriber Name:_____ Birth Date:__/__/__

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Company Name:_____

Insurance Company Address:_____

Employer:_____

SS# or Group#:_____

4. FINANCIAL AGREEMENT

I hereby authorize Eat Street Dental to submit a claim to my insurance company with the information I provide. I agree to assign all benefits to Eat Street Dental. I understand that I am responsible for all charges regardless of my insurance coverage. I agree to pay all fees for treatment provided the day of service. I consent to be billed for any appointment cancellation without a 24-hour notice.

Signature_____

Date_____

5. MEDICAL HISTORY

Physician Name:_____ Physician Phone Number:_____

Date of Last Physician visit:_____ Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had the following medical problems?

Y N Artificial Heart Valve	Y N Kidney disease	Y N Head or Neck Injuries
Y N Heart (Surgery, Disease, Attack)	Y N Thyroid or parathyroid problems	Y N Cold sores, Fever blisters
Y N Congenital Heart problems	Y N Ulcers	Y N AIDS or HIV infection
Y N Heart Murmur	Y N Digestive disorders / acid reflux	Y N Sexually-transmitted disease
Y N High Blood Pressure	Y N Diabetes	Y N Steroid medication
Y N Stroke	Y N Multiple Sclerosis	Y N Psychiatric treatment or Emotional problems
Y N High Cholesterol	Y N Neuro-muscular disease	Y N Alcohol or Drug dependency
Y N Anemia or other blood disorder	Y N Seizures, Epilepsy	Y N Do you smoke? _____Packs per day
Y N Abnormal bleeding or bruising	Y N Glaucoma or eye problems	Y N Do you use smokeless tobacco?
Y N Lung or breathing problems	Y N Hearing problems	Y N Sleep apnea or sleep problems
Y N Tuberculosis	Y N Osteoporosis or bone disorders	Y N Currently pregnant or nursing?
Y N Persistent cough or COPD	Y N Arthritis	
Y N Sinus problems	Y N Artificial Joints	Please list any other serious illness or hospitalization
Y N Asthma	Y N Cancer	not listed above:_____
Y N Liver disease	Y N Chemotherapy	
Y N Hepatitis or Jaundice	Y N Radiation therapy	_____

Are you ALLERGIC to any of the following? ☐ Penicillin or other antibiotics ☐ Aspirin or Ibuprofen ☐ Tetracycline ☐ Codeine or sedatives ☐ Latex

Please list any drugs/materials you are ALLERGIC to: _____

Do you require antibiotic pre-medication before dental treatment? ☐ Yes ☐ No

Have you ever taken bisphosphonate medications for Osteoporosis (Boniva, Reclast, Zometa, Fosamax, etc.) ☐Yes ☐No When?_____

Please list all prescription and over-the-counter medications that you are currently taking: _____

_____

6. DENTAL HISTORY

Previous Dentist:_____ Last Dental Exam Date:_____ Last Dental Xrays Date:_____

What is your reason for coming to the dentist today?_____

Is there anything you would like to change about the look or feel of your teeth? Please explain:_____

_____

Do you have any of the following dental problems?

Y N Dental fears or unfavorable experiences	Y N Teeth that are sensitive to hot or cold	Y N Clench or grind your teeth
Y N Problem with dental anesthetic or getting numb	Y N Broken teeth or fillings	Y N Jaw problems (TMJ disorder)
Y N Gums that bleed when brushing or flossing	Y N Missing teeth or loose tooth	Y N Headaches or Migraines
Y N Sore or painful teeth	Y N Poorly fitting partial or denture	Y N Dry mouth, throat and/or eyes

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. I authorize the dental staff to perform any necessary dental services with my informed consent.

Signature:_____ Date:_____

Updated Each Appointment

Initial: _____ Date: _____
Initial: _____ Date: _____
Initial: _____ Date: _____
Initial: _____ Date: _____
Initial: _____ Date: _____
Initial: _____ Date: _____
Initial: _____ Date: _____