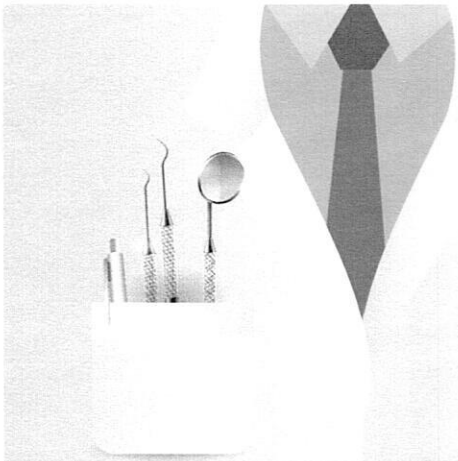

WELCOME TO...

ELDORA
FAMILY DENTISTRY & ORTHODONTICS

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date: _____ Soc. Sec. #: _____ Birthdate: _____

Name: _____ Home Phone #: _____

Address: _____ Cell Phone #: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Sex: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer: _____ Business Phone #: _____

Business Address: _____ Occupation: _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone #: _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account: _____

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____

Responsible Party Employed By: _____ Business Phone #: _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

ADDITIONAL INSURANCE

Person Responsible for Account: _____

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____

Responsible Party Employed By: _____ Business Phone #: _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

PLEASE COMPLETE REVERSE SIDE

DENTAL HISTORY

Former Dentist: _____ Date of Last X-Rays: _____

City, State: _____ How Often Do You Floss: _____

Date of Last Dental Visit: _____ How Often Do You Brush? _____

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Lips or Mouth
- ☐ Finger Nail Biting
- ☐ Grinding Teeth
- ☐ Lip of Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Frequent Headaches
- ☐ Jaw, Head or Neck Injuries
- ☐ Jaw Difficulty: Clicking and/or Pain
- ☐ Tooth Pain

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

MEDICAL CONDITIONS:

- ☐ None
- ☐ AIDS - HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Value(s)
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cold Sore/Fever Blisters
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Dementia
- ☐ Diet (Special/Restricted)
- ☐ Dizziness/Fainting
- ☐ Emphyzema
- ☐ Epilepsy
- ☐ Excessive Bleeding/Bruising
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Popping/Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Value Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Theumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Stomach Problems/Ulcer
- ☐ Stroke
- ☐ Swollen Feet or Andles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Venereal Disease
- ☐ X-Rays/Cobalt Disease

OTHER: _____

ALLERGIES: ☐ None

Are you allergic to or have you had any adverse reactions to the following:

ANTIBIOTICS	OTHER DRUGS	OTHER ALLERGIES
☐ Amoxicillin	☐ Acetaminiphen	☐ Latex
☐ Cephalexin	☐ Aspirin	☐ Metals (nickel, mercury, etc.
☐ Erythromycn	☐ Barbiturates	☐ Nuts
☐ Keflex	☐ Codeine	
☐ Penicillin	☐ Hydrocodone	
	☐ Ibuprofen	
	☐ Iodine	
	☐ Local Anetheisa	
	☐ Sulfa	

OTHER: _____

CURRENT MEDICATIONS: ☐ None

_____ _____

_____ _____

_____ _____

_____ _____

Addt'l Info: _____

_____

Are you currently under medical treatment of any kind? ☐ No ☐ Yes _____

Are you now or have you ever used a bisphospionate to treat Osteoporosis? (Actenol, Atelvia, Boniva, Fosamax) ☐ No ☐ Yes _____

Have you been admitted to a hospital or needed emergency care within the last 2 years? ☐ No ☐ Yes _____

Do you have any health issues or conditions that need further clarification? ☐ No ☐ Yes _____

☐ Pregnant Due Date:

☐ Nursing

☐ Taking Oral contraception

ASSIGNMENT AND RELEASE

i hereby authorize payment directly to Eldora Family Dentistry & Orthodontics for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize Eldora Family Dentistry & Orthodontics to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____