EASTLAND DENTAL CENTER
TRUSTED DENTISTRY

Welcome to Eastland Dental Center

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

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Last First MI Mr. Mrs. Ms. Dr.

Birth Date: ____/____/____ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Home Phone #: _____ Cell/other #: _____ Work Phone #: _____ Ext: _____ Driver's License #: _____

Where and when are the best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation : _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

Name: _____ Relation: _____ Work Phone #: _____ Home Phone #: _____

Address: _____
Street City State Zip

SPOUSE INFORMATION

Name: _____ Birth Date: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext: _____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Member ID #: _____ Insured's Birth Date: ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Member ID #: _____ Insured's Birth Date: ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today: _____

_____

Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Your current dental health is ☐ Good ☐ Fair ☐ Poor
Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No
Type of bristles on your toothbrush ☐ Hard ☐ Medium ☐ Soft
Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____
Do you have mobility in your teeth? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
Previous/Present Dentist: _____ Last Visit Date: _____
Would you like fresher breath? ☐ Yes ☐ No Whiter teeth ☐ Yes ☐ No
Straighter teeth ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? _____

_____

_____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name: _____
Address: _____
Street
_____
City State Zip

Phone #: _____ Date of last visit: _____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____
Do you smoke or use tobacco in any other form? ☐ Yes ☐ No
Have you ever taken Phen-Fen, Redux, or Pondimin? ☐ Yes ☐ No
Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No
For Women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Unsure ☐ Yes ☐ No
Week #: _____ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y☐ N☐ AIDS/HIV Positive
Y☐ N☐ Alzheimer's Disease
Y☐ N☐ Anaphylaxis
Y☐ N☐ Anemia
Y☐ N☐ Angina
Y☐ N☐ Arthritis/Gout
Y☐ N☐ Artificial Heart Valve
Y☐ N☐ Artificial Joint
Y☐ N☐ Asthma
Y☐ N☐ Blood Disease
Y☐ N☐ Blood Transfusion
Y☐ N☐ Breathing Problem
Y☐ N☐ Bruise Easily
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chest Pains
Y☐ N☐ Cold Sores/Fever Blisters
Y☐ N☐ Congenital Heart Disorder
Y☐ N☐ Convulsions
Y☐ N☐ Cortisone Medicine
Y☐ N☐ Diabetes
Y☐ N☐ Drug Addiction
Y☐ N☐ Easily Winded
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy or Seizures
Y☐ N☐ Excessive Bleeding
Y☐ N☐ Excessive Thirst
Y☐ N☐ Fainting Spells/Dizziness
Y☐ N☐ Frequent Cough
Y☐ N☐ Frequent Diarrhea
Y☐ N☐ Frequent Headaches
Y☐ N☐ Genital Herpes
Y☐ N☐ Glaucoma
Y☐ N☐ Hay Fever
Y☐ N☐ Heart Attack/Failure
Y☐ N☐ Heart Murmur
Y☐ N☐ Heart Pacemaker
Y☐ N☐ Heart Trouble/Disease
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis A
Y☐ N☐ Hepatitis B or C
Y☐ N☐ Herpes
Y☐ N☐ High Blood Pressure
Y☐ N☐ High Cholesterol
Y☐ N☐ Hives or Rash
Y☐ N☐ Hypoglycemia
Y☐ N☐ Irregular Heartbeat
Y☐ N☐ Kidney Problems
Y☐ N☐ Leukemia
Y☐ N☐ Liver Disease
Y☐ N☐ Low Blood Pressure
Y☐ N☐ Lung Disease
Y☐ N☐ Mitral Valve Prolapse
Y☐ N☐ Osteoporosis
Y☐ N☐ Pain in Jaw Joints
Y☐ N☐ Parathyroid Disease
Y☐ N☐ Psychiatric Care
Y☐ N☐ Radiation Treatments
Y☐ N☐ Recent Weight Loss
Y☐ N☐ Renal Dialysis
Y☐ N☐ Rheumatic Fever
Y☐ N☐ Rheumatism
Y☐ N☐ Scarlet Fever
Y☐ N☐ Shingles
Y☐ N☐ Sickle Cell Disease
Y☐ N☐ Sinus Trouble
Y☐ N☐ Spina Bifida
Y☐ N☐ Stomach/Intestinal Disease
Y☐ N☐ Stroke
Y☐ N☐ Swelling of Limbs
Y☐ N☐ Thyroid Disease
Y☐ N☐ Tonsilitis
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors or Growths
Y☐ N☐ Ulcers
Y☐ N☐ Venereal Disease
Y☐ N☐ Yellow Jaundice
Y☐ N☐ Steroid Therapy
Y☐ N☐ Snoring/Sleep Apnea

Please list any serious medical conditions that you have experienced: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

Are you allergic to any of the following?

Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Dental Anesthetics
Y☐ N☐ Erythromycin
Y☐ N☐ Jewelry/Metals
Y☐ N☐ Latex
Y☐ N☐ Penicillin
Y☐ N☐ Sedatives
Y☐ N☐ Sulfa Drugs
Y☐ N☐ Tetracycline
Y☐ N☐ Other

Please list anything additional that causes allergic reactions: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, and deductible, and co-payment that my insurance does not cover. I have received a copy of the offices Notice of Privacy Practices.

_____
Signature Date

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date