ADULT - Patient Information

David L. Eichler, D.M.D., P.C. (page 1 of 2)

Date: _____

Patient Name: _____

Preferred Name: _____

Mailing Address: _____

City, State, Zip: _____

- ❑ Single Sex: M or F
- ❑ Married Birthdate: (M/D/Y Format) _____-_____-_____
- ❑ Divorced Age: _____
- ❑ Widowed Soc Sec #:_____

➔ **Social Security number is mandatory if we are filing insurance** ←

Driver's License #: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Spouse's Name:_____

Birthdate ____-____-____ SS #:_____

Occupation: _____

Employer: _____

If military, please circle rank: E/1-E/4 E/5+ O/1+

Name of <u>person</u> responsible for this account if other than self?_____

Dental Insurance Information

Primary Insurance: _____

Subscriber's Name: _____

Group# _____ Relation to Patient:_____

ID# _____ Birthdate: _____-_____-_____

Secondary Insurance: _____

Subscriber's Name: _____

Group# _____ Relation to Patient:_____

ID# _____ Birthdate: _____-_____-_____

Phone Numbers

Home: _____

Work:_____

Cellular:_____

Spouse's Work:_____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

Medical History

Physician's Name: _____

Date of last physical: _____

Do you have or have you ever had any of the following:

Heart, circulatory or blood disorders	Y	N
High blood pressure	Y	N
Nervous system disorders	Y	N
Radiation treatment	Y	N
Stomach, intestinal or other disorders	Y	N
Hepatitis	Y	N
AIDS, ARC, or other STD	Y	N
Headaches related to sinuses or jaw	Y	N
Back problems	Y	N
Diabetes	Y	N
Respiratory disease	Y	N
Arthritis	Y	N
Special Diet	Y	N
Swollen neck glands	Y	N
Sinus problems	Y	N
Malignant or benign tumors	Y	N
Have you ever had to pre-medicate for a dental appointment?	Y	N

Are you currently pregnant or planning to be? _____

If yes, when is your due date? _____

Have you ever responded adversely to medical or dental treatment? Y N If yes, how so: _____

_____

Are you currently under the care of a physician **<u>or</u>** have a medical condition we should know about? Y N

If yes, what condition: _____

_____

MEDICATIONS & DRUGS

List all medications and drugs you have taken in the last 3 months (including recreational use): _____

_____

_____

_____

ALLERGIES

To medications: _____

Other: _____

<u>CONTINUED ON OTHER SIDE...</u>

Dental History

Reason for today's visit: _____

_____

Date of last complete Dental exam:_____

Date of last Dental visit: _____

Date of last Dental x-rays: _____

Have you had any of the following:

Recurrent bad breath	Y	N
Bleeding gums	Y	N
Blister on lips or mouth	Y	N
Burning sensation on tongue	Y	N
Chew on one side of mouth	Y	N
Regular tobacco use	Y	N
Regular alcoholic beverage consumption	Y	N
Clicking or popping in jaw	Y	N
Recurrent dry mouth	Y	N
Fingernail biting/Thumb sucking	Y	N
Food collecting between teeth	Y	N
Grinding teeth	Y	N
Gums swollen or tender	Y	N
Jaw pain or tiredness	Y	N
Lip or Cheek biting	Y	N
Mouth breathing	Y	N
Mouth pain while brushing	Y	N
Orthodontic Treatment	Y	N
Pain around ear(s)	Y	N
Periodontal Treatment	Y	N
Sensitivity to hot, cold, sweets	Y	N
Sensitivity when biting	Y	N
Sores or growths in your mouth	Y	N

How many times per day do you brush? _____

How many times per week do you floss? _____

Are you happy with the appearance of your teeth, face and smile? Yes No If no, why not?

_____

_____

_____

_____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

MEDICAL HISTORY RELEASE

I have answered the medical history questions on this sheet to the best of my knowledge.

INSURANCE ASSIGNMENT & RELEASE

I, the undersigned, have insurance with _____ and assign directly to Dr. David L. Eichler all benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance**. I hereby authorize the doctor 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.

All balances past 60 days (including insurance balances) will incur a $7.00 billing fee on a monthly basis until paid in full.

A $45.00 charge will be assessed for all short notice cancellations (less than 24 hours) and no shows.

We require 48 hours notice for copies of your records.

CONSENT FOR TREATMENT

I hereby give my consent for treatment for myself including diagnostic x-rays, oral examination, polishing and fluoride treatment. I have had the procedures explained and have had all questions answered to my satisfaction.

Date: _____

Signature: _____

Who may we thank for referring you?

_____

Do you have any other family members who need treatment?

Y N

CHILD - Patient Information

David L. Eichler, D.M.D., P.C. (page 1 of 2)

Date: _____

Patient Name: _____

Preferred Name: _____

Mailing Address: _____

City, State, Zip: _____

Sex: M or F

Birthdate: (M/D/Y format) _____-_____-_____ Age: _____

Mother's Name: _____

Birthdate: ____-____-____ SS# _____

➔ **Social Security number is mandatory if we are filing insurance** ←

Driver's license # _____

Occupation: _____

Employer: _____

Father's Name: _____

Birthdate: ____-____-____ SS# _____

➔ **Social Security number is mandatory if we are filing insurance** ←

Driver's license # _____

Occupation: _____

Employer: _____

Name of <u>person</u> responsible for this account?

_____

If military, please circle rank: E/1-E/4 E/5+ O/1+

Dental Insurance Information

Primary Insurance: _____

Subscriber's Name: _____

Group# _____ Relation to Patient:_____

ID# _____ Birthdate: _____-_____-_____

Secondary Insurance: _____

Subscriber's Name: _____

Group# _____ Relation to Patient:_____

ID# _____ Birthdate: _____-_____-_____

Phone Numbers

Home: _____

Mom's Work:_____Cell:_____

Dad's Work: _____ Cell:_____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

Medical History

Physician's Name: _____

Date of last physical: _____

Do you have or have you ever had any of the following:

Heart, circulatory or blood disorders	Y	N
Nervous system disorders	Y	N
Radiation treatment	Y	N
Stomach, intestinal or other disorders	Y	N
Hepatitis	Y	N
AIDS, ARC, or other STD	Y	N
Headaches related to sinuses or jaw	Y	N
Back problems	Y	N
Diabetes	Y	N
Respiratory disease	Y	N
Arthritis	Y	N
Special Diet	Y	N
Swollen neck glands	Y	N
Sinus problems	Y	N
Malignant or benign tumors	Y	N
Have you ever had to pre-medicate for a dental appointment?	Y	N

Have you ever responded adversely to medical or dental treatment? Y N If yes, how so: _____

_____

Are you currently under the care of a physician **<u>or</u>** have a medical condition we should know about? Y N

If yes, for what condition: _____

_____

MEDICATIONS & DRUGS

List all medications and drugs you have taken in the last 3 months (including recreational use): _____

_____

_____

ALLERGIES

To medications: _____

Other: _____

<u>CONTINUED ON OTHER SIDE…</u>

Dental History

Reason for today's visit: _____

_____

Date of last complete Dental exam:_____

Date of last Dental visit: _____

Date of last Dental x-rays: _____

Have you had any of the following:

Recurrent bad breath	Y	N
Bleeding Gums	Y	N
Blisters on lips or mouth	Y	N
Burning sensation on tongue	Y	N
Chew on one side of mouth	Y	N
Cigarette, pipe, or cigar smoking	Y	N
Clicking or popping in jaw	Y	N
Recurrent dry mouth	Y	N
Fingernail biting/Thumb sucking	Y	N
Food collecting between teeth	Y	N
Grinding teeth	Y	N
Gums swollen or tender	Y	N
Jaw pain or tiredness	Y	N
Lip or Cheek biting	Y	N
Mouth breathing	Y	N
Mouth pain while brushing	Y	N
Orthodontic Treatment	Y	N
Pain around ear(s)	Y	N
Periodontal Treatment	Y	N
Sensitivity to hot, cold, sweets	Y	N
Sensitivity when biting	Y	N
Sores or growths in your mouth	Y	N

How many times per day do you brush? _____

How many times per week do you floss? _____

Are you happy with the appearance of your teeth, face and smile? Yes No If no, why not?

_____

_____

_____

_____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

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A $45.00 charge will be assessed for all short notice cancellations (less than 24 hours) and no shows.

We require 48 hours notice for copies of your records.

CONSENT FOR TREATMENT

I hereby give my consent for treatment of my child including diagnostic x-rays, oral examination, polishing and fluoride treatment. I have had the procedures explained and have had all questions answered to my satisfaction.

Date: _____

Signature: _____

Parent/Guardian

Who may we thank for referring you?

_____