ADULT - Patient Information David L. Eichler, D.M.D., P.C. (page 1 of 2)

Date:	
Patient Name:	
-	
☐ Single Sex: M	
	te: (M/D/Y Format)
Divorced Age: _	
	c #:
	ber is mandatory if we are filing insurance 🗲
	
Employer Address:	
Cravas's Name	
	GC #-
	SS #:
• •	e rank: $E/1-E/4$ $E/5+$ $O/1+$
• •	sible for this account if other than
self?	
	surance Information
Primary Insurance: _	
Primary Insurance: Subscriber's Name:	
Primary Insurance: Subscriber's Name:	
Primary Insurance: _ Subscriber's Name: _ Group# _	
Primary Insurance: _ Subscriber's Name: _ Group# _	Relation to Patient:
Primary Insurance: _ Subscriber's Name: _ Group# _ ID# _	Relation to Patient: Birthdate:
Primary Insurance: _ Subscriber's Name: Group# ID# Secondary Insurance:	Relation to Patient: Birthdate:
Primary Insurance: Subscriber's Name: Group# ID# Secondary Insurance: Subscriber's Name:	Relation to Patient: Birthdate:
Primary Insurance: _ Subscriber's Name: _ Group# _ ID# _ Secondary Insurance: Subscriber's Name: _ Group# _	Relation to Patient: Birthdate: Relation to Patient:
Primary Insurance: _ Subscriber's Name: _ Group# _ ID# _ Secondary Insurance: Subscriber's Name: _ Group# _	Relation to Patient: Birthdate:
Primary Insurance: _ Subscriber's Name: _ Group# ID# Secondary Insurance: Subscriber's Name: _ Group# ID# ID#	Relation to Patient: Birthdate: Relation to Patient:
Primary Insurance: _ Subscriber's Name: _ Group# _ ID# _ Secondary Insurance: Subscriber's Name: _ Group# _ ID# _ Ph	Relation to Patient: Birthdate: Relation to Patient: Birthdate: None Numbers
Primary Insurance: _ Subscriber's Name: _ Group# _ ID# _ Secondary Insurance: Subscriber's Name: _ Group# _ ID# _ Ph Home: _	Relation to Patient: Birthdate: Relation to Patient: Birthdate: One Numbers
Primary Insurance: _ Subscriber's Name: _ Group# _ ID# _ Secondary Insurance: Subscriber's Name: _ Group# _ ID# _ Ph Home: _ Work: _	Relation to Patient: Birthdate: Relation to Patient: Birthdate:
Primary Insurance: _ Subscriber's Name: _ Group# ID# Secondary Insurance: Subscriber's Name: _ Group# ID# Ph Home: Work: Cellular:	Relation to Patient: Birthdate: Relation to Patient: Relation to Patient: Birthdate: One Numbers
Primary Insurance: _ Subscriber's Name: _ Group# ID# Secondary Insurance: Subscriber's Name: _ Group# ID# Ph Home: Work: Cellular:	Relation to Patient: Birthdate: Relation to Patient: Birthdate:
Primary Insurance: _ Subscriber's Name: _ Group# ID# Secondary Insurance: Subscriber's Name: _ Group# ID# Ph Home: Work: Cellular: Spouse's Work:	Relation to Patient: Birthdate: Relation to Patient: Birthdate: One Numbers
Primary Insurance: Subscriber's Name: Group# ID# Secondary Insurance: Subscriber's Name: Group# ID# Ph Home: Work: Cellular: Spouse's Work: IN CASE OF EMERG	Relation to Patient: Birthdate: Relation to Patient: Birthdate: One Numbers GENCY, CONTACT:
Primary Insurance: Subscriber's Name: Group# ID# Secondary Insurance: Subscriber's Name: Group# ID# Ph Home: Work: Cellular: Spouse's Work: IN CASE OF EMERGName:	Relation to Patient: Birthdate: Relation to Patient: Birthdate: One Numbers

Medical History

Physician's Name:	•	
Date of last physical:		
D 1 1 1 1 1	C .1	C 11 '
Do you have or have you ever had any		C
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?		
if yes, when is your due dute.		
Have you ever responded adversely to treatment? Y N If yes, how so:		
Are you currently under the care of a p medical condition we should know about the yes, what condition:	out? Y	N
MEDICATIONS &	DRUC	GS
List all medications and drugs you hav months (including recreational use):		
ALLERGIES		
To medications:		
Other:		
CONTINUE		146

CONTINUED ON

Dental History

Reason for today's visit:			MEDICAL HIS
Date of last complete Dental exam:			I have answered the medical h
Date of last Dental visit:			the best of my knowledge.
Date of last Dental x-rays:			
Have you had any of the following:			INSURANCE ASSI
Have you had any of the following: Recurrent bad breath	Y	N	I, the undersigned, have insura
Bleeding gums	Y	N	and assign directly to Dr. Day
Blister on lips or mouth	Y	N	otherwise payable to me for so
Burning sensation on tongue	Y	N	that I am financially respons
Chew on one side of mouth	Y	N	not paid by my insurance. I
	Y		release all information necess
Regular tobacco use	Y	N N	benefits. I authorize the use of
Regular alcoholic beverage consumption	Y	N N	insurance submissions whether
Clicking or popping in jaw	Y	N	
Recurrent dry mouth		N	All balances past 60 days (in
Fingernail biting/Thumb sucking	Y	N	will incur a \$7.00 billing fee
Food collecting between teeth	Y	N	in full.
Grinding teeth	Y	N	
Gums swollen or tender	Y	N	A \$45.00 charge will be asse
Jaw pain or tiredness	Y	N	cancellations (less than 24 he
Lip or Cheek biting	Y	N	
Mouth breathing	Y	N	We require 48 hours notice
Mouth pain while brushing	Y	N	
Orthodontic Treatment	Y	N	CONSENT FO
Pain around ear(s)	Y	N	I hereby give my consent for t
Periodontal Treatment	Y	N	diagnostic x-rays, oral examir
Sensitivity to hot, cold, sweets	Y	N	treatment. I have had the prod
Sensitivity when biting	Y	N	all questions answered to my
Sores or growths in your mouth	Y	N	
			Date:
How many times <u>per day</u> do you brush?			
How many times <u>per week</u> do you floss?			Signature:
A server have serial the server server of server	(1. C	1	
Are you happy with the appearance of your t	eetn, rac	e and	
smile? Yes No If no, why not?			Who may we thank for referri
			Do you have any other family Y N
			1 IN
			-

PLEASE READ THE FOLLOWING CAREFULLY AND **SIGN BELOW:**

TORY RELEASE

story questions on this sheet to

INMENT & RELEASE

nce with ___ d L. Eichler all benefits, if any, vices rendered. **I understand** ble for all charges whether or hereby authorize the doctor to ry to secure the payment of this signature on all my manual or electronic.

eluding insurance balances) on a monthly basis until paid

sed for all short notice urs) and no shows.

or copies of your records.

R TREATMENT

eatment for myself including tion, polishing and fluoride edures explained and have had atisfaction.

Pate:
ignature:
Who may we thank for referring you?

members who need treatment?

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:

Medical History

Physician's Name:		
Date of last physical:		
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Do you have or have you ever had any		•
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 treatment? Y N If yes, how so:		
Are you currently under the care of a p medical condition we should know about If yes, for what condition:	out? Y	N
MEDICATIONS & List all medications and drugs you hav months (including recreational use):	e taken	
ALLERGIES		
To medications:	•	
Other:		
CONTINUE OTHER SI		

Dental History

Reason for today's visit:			
Date of last complete Dental exam:_			MEDICAL HISTORY R I have answered the medical history que
Date of last Dental visit:			the best of my knowledge.
Date of last Dental x-rays:			the best of my knowledge.
Have you had any of the following:			INSURANCE ASSIGNMENT I, the undersigned, have insurance with
Recurrent bad breath	Y	N	and assign directly to Dr. David L. Eich
Bleeding Gums	Y	N	otherwise payable to me for services rer
Blisters on lips or mouth	Y	N	that I am financially responsible for a
Burning sensation on tongue	Y	N	not paid by my insurance. I hereby au
Chew on one side of mouth	Y	N	release all information necessary to secu
Cigarette, pipe, or cigar smoking	Y	N	benefits. I authorize the use of this sign
Clicking or popping in jaw	Y	N	insurance submissions whether manual
Recurrent dry mouth	Y	N	
Fingernail biting/Thumb sucking	Y	N	All balances past 60 days (including in
Food collecting between teeth	Y	N	will incur a \$7.00 billing fee on a mon
Grinding teeth	Y	N	in full.
Gums swollen or tender	Y	N	A #47.00 1 911 1.6
Jaw pain or tiredness	Y	N	A \$45.00 charge will be assessed for a
Lip or Cheek biting	Y	N	cancellations (less than 24 hours) and
Mouth breathing	Y	N	We magnine 40 houng notice for comics
Mouth pain while brushing	Y	N	We require 48 hours notice for copies
Orthodontic Treatment	Y	N	CONSENT FOR TREA
Pain around ear(s)	Y	N	I hereby give my consent for treatment
Periodontal Treatment	Y	N	diagnostic x-rays, oral examination, pol
Sensitivity to hot, cold, sweets	Y	N	treatment. I have had the procedures ex
Sensitivity when biting	Y	N	all questions answered to my satisfactio
Sores or growths in your mouth	Y	N	an questions answered to my satisfaction
How many times per day do you bru			Date:
How many times per week do you fl	oss?		Signature:
Are you happy with the appearance smile? Yes No If no, wh	•	eth, face and	Parent/Guardian
			Who may we thank for referring you?
		-	

PLEASE READ THE FOLLOWING CAREFULLY AND **SIGN BELOW:**

ELEASE

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Γ & RELEASE

ler all benefits, if any, ndered. I understand all charges whether or thorize the doctor to ire the payment of ature on all my or electronic.

nsurance balances) thly basis until paid

ll short notice no shows.

of your records.

ATMENT

of my child including ishing and fluoride plained and have had

Pate:	
ignature:	
Parent/Guardian	
Who may we thank for referring you?	