

PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT INFORMATION:

Name: _____ Birth Date: _____ Age: _____
Address: _____ Social Security #: _____
City: _____ State: _____ Zip: _____ Drivers License #: _____
Employer: _____ Home Phone #: _____
Business Address: _____ Work Phone #: _____
Occupation: _____ Cell Phone #: _____
Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

SPOUSE/PARENT/GUARDIAN INFORMATION:

Name: _____ Birth Date: _____ Age: _____
Address: _____ Social Security #: _____
City: _____ State: _____ Zip: _____ Drivers License #: _____
Employer: _____ Home Phone #: _____
Business Address: _____ Work Phone #: _____
Occupation: _____ Cell Phone #: _____

Seasonal Resident? Yes No Date you leave: _____ Date you return: _____

Seasonal Out-of-Town Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: _____

Closest relative not living with you: _____ Relationship: _____

Address: _____ State: _____ Zip: _____ Phone #: _____

Do you know anyone who has been treated in our office? Yes No Whom? _____

Who referred you to our office? _____

DENTAL INSURANCE INFORMATION

Company: _____ Subscriber's Name: _____
Address: _____ ID#: _____
City: _____ State: _____ Zip: _____ Group #: _____
Phone #: _____ (_____) _____

PATIENT RESPONSIBLE FOR ALL FEES: All professional services rendered are charged to the patient or responsible party. Necessary forms will be completed to expedite insurance carrier's payment.

INSURANCE AUTHORIZATION: I hereby authorize Dr. Eastman to furnish information to my insurance carriers concerning my treatments, and I hereby assign to them all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance.

SIGNATURE ON FILE: _____ **DATE:** _____

Dr. Lindsay B. Eastman, D.D.S., M.S., P.A.

Patient Consent to Receive Mail and/or Telephone Message

Name: _____ DOB: _____
(Last Name) (First Name) (M.I.)

Do we have permission to:

Send a yearly appointment card to your home? Y____ N____

Send test results to your home? Y____ N____

Leave the following information on your home answering machine/voice mail?

Appointment Information Y____ N____
Billing Information Y____ N____
Medical Information Y____ N____

Leave the following information on your work answering machine/voice mail?

Appointment Information Y____ N____
Billing Information Y____ N____
Medical Information Y____ N____

Leave the following information on your cell phone voice mail?

Appointment Information Y____ N____
Billing Information Y____ N____
Medical Information Y____ N____

I give permission to share appointment information with the person named below:

Name: _____
(Last Name) (First Name) (Relationship)

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: _____
(Last Name) (First Name) (Relationship)

Name: _____
(Last Name) (First Name) (Relationship)

I give permission to share billing information with the person listed below:

Name: _____
(Last Name) (First Name) (Relationship)

Signature of Patient: _____ Date: _____

HEALTH INFORMATION

Circle One

1. Are you having pain or discomfort at this time?..... YES NO
2. Do you feel nervous about having dental treatment?..... YES NO
3. Have you had a bad experience in the dental office?..... YES NO
4. Have you been a patient in the hospital during the past two years?..... YES NO
5. Have you been under the care of a medical doctor during the past two years?..... YES NO
 Physician's Name: _____ Phone: _____
 Pharmacy Name: _____ Phone: _____
6. Are you taking any medication, drugs, pills, aspirin, vitamins, herb, or other over the counter medications? YES NO
 If yes, please list below: _____

7. Have you taken any antibiotics in the last 8 weeks? Yes No What? _____
8. Are you taking or have you ever taken any of the following medications:
 Fosamax / Actonel / Aredia / Didronel / Zometa / Boniva
9. Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Demerol	Local Anesthetic/Novocain	Percodan	Valium
Codeine	Erythromycin	Other Antibiotics	Sleeping Pills	
Darvocet	Iodine/Shellfish	Penicillin	Tetracycline	
10. Are you aware of being allergic to any other medications or substances? Yes No If yes, please list below:

11. Circle any of the following which you have had or have at present:

Allergies or Hives	Cortisone Medicine	Heart Failure	Osteoporosis	Tuberculosis (TB)
Anemia	Cosmetic Surgery	Hemophilia	Pain in Jaw Joints	Ulcers
Angina Pectoris	Cough	Hepatitis A (infectious)	Psychiatric Treatment	Venereal Disease
Arthritis	Diabetes	Hepatitis B (serum)	Radiation Therapy	X-Ray/Cobalt Treatment
Asthma	Drug Addiction	High Blood Pressure	Rheumatism	
Blood Transfusion	Emphysema/COPD	HIV + / A.I.D.S.	Sickle Cell Disease	Yellow Jaundice
Bruise Easily	Epilepsy or Seizures	Kidney Trouble	Sinus Trouble	
Chemotherapy	Fainting or Dizzy Spells	Liver Disease	Sleep Apnea	
Cold Sores	Glaucoma	Nervousness	Stroke/TIA	
Canker Sores	Heart Disease / Attack	Osteopenia	Thyroid Disease	
12. Do you premedicate with antibiotics for dental appointments? Yes No Antibiotic Type: _____

Artificial Heart Valve	Heart Murmur	Heart Surgery	Rheumatic Fever
Artificial Joints(Hip, Knee)	Heart Pacemaker	Mitral Valve Prolapse	Scarlet Fever
13. Do you use tobacco products?..... YES NO
 Packs per day: _____ Type: _____ When Stopped: _____
14. Do you use alcohol?..... YES NO
15. Has your medical doctor ever said you have cancer or a tumor?..... YES NO
16. Do you have any disease, condition, or problem not listed?..... YES NO

FOR WOMEN ONLY:

Are you pregnant? Yes No If yes, how far along are you?_____ Are you taking birth control pills? Yes No

DENTAL HISTORY:

Dentist's Name: _____ How Long?: _____

How many times a year do you have your teeth cleaned?_____ Date last cleaned ____/____/____

Do you floss daily? Yes No How/who made you aware of a concern in your mouth? _____

Do you have a concern with losing your teeth or someday wearing dentures?.....YES NO

Do you notice a bad taste/odor in your mouth?..... YES NO

Tender/bleeding gums when brushing?..... YES NO

Do you feel your teeth are loose?..... YES NO

Are your teeth sensitive to hot/cold?..... YES NO

Have you had an oral abscess?..... YES NO

Does food trap easily between teeth?..... YES NO

Are you aware of clenching or grinding your teeth?..... YES NO

Do you have a tendency to gag?..... YES NO

Do you have difficulty breathing through your nose?..... YES NO

Do you have any concerns with getting numb?..... YES NO

Do you have a back problem that will prevent you from lying back in our chair?..... YES NO

Do you have headaches? Yes No Upon awakening? Yes No Under Stress? Yes No

Have you undergone orthodontics (braces)? Yes No When?_____ Where?_____ Dr.?_____

Have you seen a periodontist before? Yes No When?_____ Where?_____ Dr.?_____

What was done at the time?_____

Please make additional comments you feel we should know. _____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____