EAGLE ROCK DENTAL CARE
Personalized & Comfortable

PATIENT INFORMATION

NAME: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT.# CITY STATE ZIP

PHONE NUMBERS: ☐ _____ ☐ _____ ☐ _____
HOME CELL WORK/OTHER

BIRTH DATE: _____ S.S.# _____ EMAIL: _____
MO DAY YR

NAME OF EMPLOYER: _____

I would like to receive appointment reminders via email or text message ☐ E-MAIL ☐ TEXT MESSAGE

Has any member of your family been treated in our office? ☐ YES ☐ NO if yes, whom _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

RESPONSIBLE PARTY or INSURANCE HOLDER ☐ self ☐ spouse ☐ mother ☐ father ☐ guardian

NAME: _____ BIRTH DATE: _____
LAST FIRST M MO DAY YR

ADDRESS: _____
STREET APT# CITY STATE ZIP

INSURANCE COMPANY: _____ GROUP# _____

SS# _____ SUBSCRIBER ID# _____

EMPLOYER _____

EMERGENCY CONTACT

Emergency Contact Outside of Immediate Family/Household

NAME: _____

RELATIONSHIP to PATIENT _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

AUTHORIZATION

I hereby authorize payment directly to Eagle Rock Dental Care of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Eagle Rock Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

x _____
☐ Patient ☐ Father ☐ Mother ☐ Spouse ☐ Guardian

PATIENT NAME_____ DATE _____

Primary Reason for this Dental Visit: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

What may we do for you? _____

Do you have dental examinations on a routine basis? Last Visit: _____ ☐ Yes ☐ No

Name of previous dentist (optional) _____

Do your gums ever bleed? _____ ☐ Yes ☐ No

If you could change anything about your teeth/smile, what would you change?_____

What would you like your teeth to be like in twenty years? _____

Do you ever have clicking, popping, or discomfort in the jaw? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Do you have any sores or growths in your mouth? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

MEDICAL HISTORY

Are you under a physician's care now? ☐ Yes ☐ No Who?_____

Physician Phone_____ Why? _____

What special accommodations may we provide for you?_____

Have you ever been hospitalized or had a major operation? _____ ☐ Yes ☐ No

Have you ever had a serious injury to your head or neck? _____ ☐ Yes ☐ No

Are you taking any medications, pills, or drugs? What? _____ ☐ Yes ☐ No

_____

Are you on a special diet? _____ ☐ Yes ☐ No

Are you allergic to any medication? Please check box below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_____ ☐ Yes ☐ No

WOMEN (please check): ☐ Pregnant ☐ Taking Oral Contraceptive _____ ☐ Yes ☐ No

Have you had, or are you currently experiencing, any of the following? Circle/Check any that apply.

☐ Heart Trouble/Disease	☐ Sinus Trouble	☐ Hepatitis A, B, C	☐ Leukemia
☐ Mitral Valve Prolapse	☐ Asthma	☐ HIV	☐ Recent Blood Transfusion
☐ Artificial Heart Valve	☐ Lung Disease	☐ Drug Addiction	☐ Epilepsy or Seizures
☐ Heart Surgery	☐ Breathing Problem	☐ High Blood Pressure	☐ Fainting or Dizziness
☐ Kidney Problems	☐ Emphysema	☐ Stroke	☐ Glaucoma
☐ Thyroid Disease	☐ Tuberculosis	☐ Blood Disease	☐ Alzheimer's Disease
☐ Arthritis/Gout	☐ Cancer/Radiation/Chemotherapy	☐ Bruise Easily/Anemia	☐ Allergies (Pollen/Dust)
☐ Pain in Jaw Joints	☐ Diabetes	☐ Excessive Bleeding	☐ Mental/Emotional Impairment
☐ Cortisone Medicine	☐ Hypoglycemia	☐ Sickle Cell Disease	
☐ Artificial Joint	☐ Liver Disease	☐ Hemophilia(Bleeding Problem)	

Have you ever had any serious illness not checked above? ☐ Yes ☐ No Discuss_____

Emergency Contact _____ Phone _____

To the best of my knowledge, all the preceding answers are correct.

X_____ Date _____

Patient Signature (parent or guardian)

Reviewed by Provider_____ Date _____

History View and Significant Findings_____

_____

Please report any changes to your medical history, including change in medication, to our staff at your next appointment.