PATIENT INFORMATION

			y
NAME:	☐ MAI	RRIED□ SINGLE□ 1	MINOR□MALE □FEMALE
	M		
ADDRESS: STREET APT.#	CITY	STATE	ZIP
2-1-1-1			
PHONE NUMBERS: HOME		OPL I	WODW/OTHER
номе		CELL	WORK/OTHER
BIRTH DATE: S.S.# S.S.#		EMAIL:	
MO DAI IR			
NAME OF EMPLOYER:		<u> </u>	
I would like to receive appointment reminders v	via email or tev	t message F-MAII	□TEXT MESSAGE
1 would like to receive appointment reminders v	via ciliali di tex	t message <u> </u>	L LIEAT MESSAGE
Has any member of your family been treated in	our office?	YES \square NO if yes, who	om
Whom may we thank for referring you to our or	ffice?		
FAMILY INFORMATION			
RESPONSIBLE PARTY or INSURANCE H		galf Danayga Dmath	or Ofothor Oguardian
RESPONSIBLE PARTY OF INSURANCE H	OLDER 🗀	sen 🗀 spouse 🗀 noui	
NAME: LAST FIRST	M	BIRTH DATE:	4O DAY YR
		IV	IO DAI IK
ADDRESS: STREET AP	Γ# CIT	Y ST	TATE ZIP
INSURANCE COMPANY:		GROUP#	
SS#SUBSC	RIBER ID#		
EMPLOYER			ORIZATION
EMIF LOTER		Activ	ORIZATION
EMERGENCY CONTACT			ayment directly to Eagle Rock
			roup insurance benefits otherwis erstand that I am responsible for
Emergency Contact Outside of Immediate Famil	y/Household	all costs of dental tre	eatment. I hereby authorize Eagle
NAME:			administer such medications and stic and therapeutic procedures
		as may be necessary	for proper dental care. The
RELATIONSHIP to PATIENT			page and the dental/medical to the best of my knowledge. I
ADDRESS:		grant the right to the	dentist to release my
CITY/STATE/ZIP:			ries and other information about to third party payers and/or othe
		health professionals.	
PHONE:	Λ		
		Patient	Mother □Spouse □Guardia

PATIENT NAME_			DATE	
Primary Reason for this Dental	Visit: □Examination □Emerg			
DENTAL HISTORY What	at may we do for you?			
Do you have dental examination	ns on a routine basis? Last Visit: _			
Name of previous dentist (option	nal)			
Do your gums ever bleed?				□Yes □No
	out your teeth/smile, what would			
	to be like in twenty years?			
Do you ever have clicking, popping, or discomfort in the jaw? ☐ Yes ☐ No Do you have any sores or growths in your mouth? ☐ Yes ☐ No			Do you grind your teeth? Do you use tobacco?	
	you under a physician's care nov Why?			
	nay we provide for you?			
Have you ever been hospitalized or had a major operation?				
Are you taking any medications, pills, or drugs? What?				
Are you on a special diet?				□Yes□No
Are you allergic to any medicati				
☐ Aspirin ☐ Penicillin ☐ Codei	ne □Acrylic □Metal □Latex R	Rubber Other		
	Taking Oral Contraceptive			
	tly experiencing, any of the follow		any that apply.	
☐ Heart Trouble/Disease ☐ Mitral Valve Prolapse ☐ Artificial Heart Valve ☐ Heart Surgery ☐ Kidney Problems ☐ Thyroid Disease ☐ Arthritis/Gout ☐ Pain in Jaw Joints ☐ Cortisone Medicine ☐ Artificial Joint	☐ Sinus Trouble ☐ Asthma ☐ Lung Disease ☐ Breathing Problem ☐ Emphysema ☐ Tuberculosis ☐ Cancer/Radiation/Chemotherapy ☐ Diabetes ☐ Hypoglycemia ☐ Liver Disease	Hepatitis A, B, C HIV Drug Addiction High Blood Pressur Stroke Blood Disease Bruise Easily/Aner Excessive Bleeding Sickle Cell Disease	Glaucoma Alzheimer's Dise inia Allergies (Pollen/ Mental/Emotional	res ness ase Dust)
Have you ever had any serious ill	ness not checked above? Yes	No Discuss		
Emergency Contact Phone				
	To the best of my knowledge, all th	he preceding answers ar	re correct.	
X	an)		Date	
Patient Signature (parent or guardia	an)			
Reviewed by Provider			Date	
History View and Significant Findings				