H. Nelson Eddy, DDS, P.A.

PATIENT INFORMATION

Last Name: _____ First:_____ MI:_____ Sex: M/F DOB: __/__/___ Age:____
Mailing Address: _____ City: _____ State:_____ Zip:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Home Number:_____ Work Phone:_____ Cell Phone:_____
Employer:_____ City:_____ State:_____ Occupation:_____
Email:_____
What is the best way to contact you? Home Phone Work Phone Cell Phone Email Text Message
Single / Married Name of Spouse/Closest Relative:_____ Phone #_____
If you are completing this form for another person, what is your relationship to that person?_____

Parent/Guardian (Please complete this section if patient is a minor.)

Last Name: _____ First:_____ MI:_____ Sex: M/F DOB: __/__/___ Age:____
Mailing Address: _____ City: _____ State:_____ Zip:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Home Number:_____ Work Phone:_____ Cell Phone:_____
Employer:_____ City:_____ State:_____ Occupation:_____
Email:_____

Dental Insurance Information (Please provide your insurance card to photocopy.)

Primary Dental Insurance

Employee's name:_____
ID#_____ DOB:___/___/___
Employer:_____
Insurance Co._____
Ins. Co. Address:_____
City/State/Zip:_____
Ins. Co. Phone#_____
Group#_____

Secondary Dental Insurance

Employee's name:_____
ID#_____ DOB:___/___/___
Employer:_____
Insurance Co._____
Ins. Co. Address:_____
City/State/Zip:_____
Ins. Co. Phone#_____
Group#_____

Responsibility Statement

Payment in full is expected when services are rendered. We accept cash, personal checks, VISA, MasterCard, American Express and Discover. We also offer interest free financing. We will file insurance claims on your behalf and benefits are mailed directly to the insured. Your insurance is a method for you to receive reimbursement for fees you have paid to or incurred with the doctor for services rendered. I agree to be financially responsible for all charges.

I, the undersigned patient/guardian, hereby authorize the release of my information for treatment, payment and other health care operations. I have read the above information and understand it.

_____ ___/____/____ _____ ___/___/____
Signature/Signature of Parent or Guardian Witness

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Medical / Dental History **Date_____/_____/_____**

Name:_____ DOB:_____/_____/_____ Sex: M / F
Height:_____ Weight:_____
Single / Married Name of Spouse / Closest Relative: _____ Phone#_____
If you are completing this form for another person, what is your relationship to that person? _____
Referred by:_____ General Dentist: _____
Physician:_____ Phone #_____ Last Exam:_____

The answers to the following questions are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some additional questions about your responses to this questionnaire.

Current Medications (Prescription, Over-the counter, and herbal)

Medication	Dosage	Frequency		Medication	Dosage	Frequency

Pre-Med required? Yes No
Reason? _____
Type: _____

Allergic reactions? Yes No
Medications: _____
Latex Allergy? Yes No
Other Allergies: _____

Are you currently under a physician's care? If so, please explain. _____
_____
Have you been hospitalized or had any surgery in the last 5 years? Please explain. _____
_____
Do you smoke or use tobacco products? Yes No If so, How much? _____

Please indicate if you have or have had any of the following:

Head/Neck/Mouth Injuries		Hepatitis	
Heart Trouble		Jaundice or Liver Disease	
Heart Disease		Thyroid Disease	
Angina		Blood Transfusion	
Rheumatic Fever		Glaucoma	
Kidney Disease		Past use of Fenphen	
Dialysis		Heart Murmur	
Eating Disorder		Mitral Valve Prolapse	
Stomach Reflux		Heart Surgery	
Stomach Ulcer		Artificial Heart Valves	
Immunological Disease		Pacemaker	
Sjogren's Disease		Indwelling Defibrillator	
Fibromyalgia		Artificial Joints	
Autoimmune Disease (lupus, pemphilus, etc.)		Organ Transplant	
Arthritis or joint disorder		High Blood Pressure	
Diabetes Type: _____ Controlled? Y N		Low Blood Pressure	

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Headaches		Stroke	
Depression		Bleeding Problems	
Psychiatric Disorders		Hemophilia	
Neurological Disease		Anemia	
Convulsions		Leukemia	
Epilepsy / Seizures		Lung Disease	
Cerebral palsy		Emphysema	
Fainting / Dizziness		Shortness of breath	
Persistent Diarrhea		Asthma	
Weight Loss		Sleep Apnea	
Aids / HIV positive		Tuberculosis	
Alcohol or chemical dependency		Sinus Trouble	
Chemotherapy		Cancer	
Osteoporosis		Radiation Treatment to head/neck	

Women only: Are you pregnant? Yes No
Are you Nursing? Yes No
Are you using oral contraceptives? Yes No
Are you undergoing fertility treatment or taking fertility drugs? Yes No

Do you have any disease, condition or problem not listed above? Please explain. _____
_____
_____

Have you had any serious trouble associated with previous dental treatment? _____
_____
_____

Is there any other information you would like the doctor to know? _____
_____
_____

Have you ever been treated with bisphosphonate medications? Yes No When? _____
(Fosomax, Actonel, Boniva, Zometa, etc.)

Dental History

Last dental visit: ___/___/___ Last dental cleaning: ___/___/___ Frequency of cleanings: _____
What is your chief dental concern? _____
Have you ever had any periodontal treatment? Yes No How long ago? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____/_____/_____
Signature/Signature of parent or guardian Date