HEALTH QUESTIONNAIRE FOR e-DENTAL GROUP

****CONFIDENTIAL****

Patient's Full Name _____ **Preferred Name** _____

Patient's Birth Date_____ **Social Security** _____ **Male** ___ **Female** ___

Home Phone _____ **Work** _____ **Cell** _____

Address _____ **City** _____ **State** ___ **Zip Code** _____

Email _____ **Would you like reminders by email? Y**___ **N**___

Patient's Physician _____ **Physician's Phone** _____

Patient's Dentist _____ **Patient's Orthodontist** _____

Emergency Contact _____ **Phone Number** _____

REFERRAL INFORMATION

Whom may we thank for referring you to e-dental? _____

A patient ____ **Friend** ____ **Relative** ____ **Insurance** ____ **Web page** ____ **Yellow pages** ____ **Newspaper**_____

Have you had any of the following?

__ Anemia
__ Anxiety
__ Arthritis/Rheumatism
__ Artificial heart valve
__ Artificial joint
_____
__ Asthma
__ Benign growths
__ Bisphosphonate meds. (fosamax, boniva, actonel)
__ Blood vessel grafts
__ Bronchitis
__ Cancer_____
__ Radiation treatment
__ Chemotherapy
__ Cirrhosis
__ COPD
__ Cortisone/ACTH
__ Cough or flu
__ Depression
__ Diabetes I or II
__ Difficulty opening
__ Emphysema
__ Excessive bleeding
__ Fainting
__ Glaucoma
__ Head injuries
__ Heart attack
__ Heart failure
__ Heart murmur
__ Heart surgery
__ Heart trouble
__ Hemophilia
__ Hepatitis A, B, C
__ High blood pressure
__ HIV/AIDS
__ Hyperthyroid
__ Immune deficiencies
__ Irregular heart beat
__ Jaundice
__ Kidney disease
__ Liver disease
__ Loud snoring
__ Low thyroid
__ Thyroid removal
__ Replacement therapy
__ Lung disease
__ Mitral valve prolapse
__ Nasal obstruction
__ Nervous disorders
__ Organ transplant
__ Pacemaker
__ Pregnancy- currently
Due Date_____
__ Psychiatric treatment
__ Recent illness
__ Rheumatic fever
__ Seizures/epilepsy
__ Shortness of breath
__ Sinus problems
__ Stomach problems
__ GERD
__ Ulcers
__ Stroke
__ TMJ problems
__ Tuberculosis
__ Venereal disease

ARE YOU ALLERGIC TO:

__ Aspirin
__ Barbiturates
__ Codeine
__ Eggs or egg whites
__ Latex
__ Novocain- local anesthetics
__ Penicillin/Amphicillin/Amoxicillin
__ Sulfa drug

Adverse reaction to any other:

_____

Other health problems not listed:

_____
_____

Office Use Only

BP: _____

PR: _____

YES NO

__ __ Are you in good health?
__ __ Are you having pain or discomfort at this time?
__ __ Have you had a bad experience with previous dental or surgical treatment?
__ __ Have you been under the care of a physician or hospitalized during the past two years?
If yes, explain_____
_____
__ __ Have you ever gone to sleep for an operation? If yes, explain. Any complications?_____
_____
__ __ Have you ever had any complications following dental treatment? If yes, explain_____
_____
__ __ Have any immediate family members had a serious reaction to a general anesthetic? _____
__ __ Are you taking medicines of any kind, including aspirin, diet pills or vitamins? Please list:
_____
_____
__ __ Have you ever used recreational or IV drugs (marijuana, cocaine, etc.) or Phen/Fen? Please list: _____
__ __ Do you smoke or use smokeless tobacco? If yes, how long _____ How much per day?_____
__ __ Do you wear dentures/partials?
__ __ Do you wear contacts?
__ __ Have you undergone eye surgery in the past 8 weeks?
__ __ Do you have a specific dental problem you would like to address?_____
_____
__ __ Do you have dental exams on a regular basis?
__ __ Are your teeth sensitive to: cold_____ hot_____ sweet_____ biting_____ touch_____
__ __ Do you think you have active decay?
__ __ Do you think you have gum disease?
__ __ Do your gums bleed?
__ __ Have you been taught how to control gum disease?
__ __ Do you brush your teeth? How often: twice daily__ once daily__ weekly__ not regularly__
__ __ Do you floss your teeth? How often: twice daily__ once daily__ weekly__ not regularly__
__ __ Have you had: scaling or root planing__ gum surgery__ TMJ therapy__surgery__ braces__
__ __ Do you clench or grind your teeth?
__ __ Do you wear a grinding guard/night guard?
__ __ Do you have clicking or popping in your jaw joint?
__ __ Do you have human papillomavirus (HPV) or a history of HPV?
__ __ Do you have any sores, ulcers or growths in your mouth?_____
__ __ Do you drink alcoholic beverages? If yes how often? Never__ seldom__ more than 2 a day__
__ __ Do you have fear of dental treatment?
__ __ Are you pleased with the appearance of your teeth?
__ __ Would you like to have your teeth whitened?
__ __ Do you think you have bad breath?
__ __ Are you under the care of a Physician? Please explain:_____
_____
_____
Describe any other changes you would like in the appearance of your teeth: _____
_____
_____
Do you have any other information you think we should know about? _____
_____
_____
To the best of my knowledge, all the preceding answers are true and correct. If I have any change in health status, or if my medications change, I will inform the doctor accordingly.

Patient Signature: _____
Dentist Signature: _____
Date: _____

PRACTICE POLICIES

Financial Responsibility

-Payment for services is due at the time of your appointment

-We process your payment by personal check as an electronic debit. For any reason your check is not authorized through Retriever, another form of payment is due at the time of your appointment.

-For balances not paid within 30 days of statement date, the account will be sent for collection.

Insurance

I authorize release of any dental information necessary to process insurance claims. I also request payment of benefits to be made to Dr. Althea Eggleston, DDS, PA.

Insurance Claims: Providing quality medical care for our patients is our primary concern. It is extremely difficult to keep track of all insurance plans requirements. Each plan has different guidelines regarding benefits provided. If you do not inform us of any special requirements in your contract and we order services that are not covered, we will have no choice but to bill you directly for those charges. You are responsible for your own insurance.

Quotes given for proposed treatment are just an estimate. Balances remaining after insurance pays is your responsibility and due within 30 days of the issued statement.

Missed Appointment Policy

Our practice is dedicated to quality care and exceptional service. We spend extensive amounts of time preparing for your visit. Broken and missed appointments result in financial hardship for our office and create scheduling problems for other patients. If you find that you must change your appointment, we require a minimum of 24 hours notice so that we may make every effort to accommodate other patients.

-If proper notice is not received, a fee of $50 will be charged for every hour of allotted time cancelled.

-This fee will apply to all patients.

Consent for Treatment

-I hereby authorize doctor or designated staff to take radiographs, dental impressions, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs

-Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

-I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I HAVE READ AND UNDERSTAND THE "PRACTICE POLICIES"

_____ _____

Patient Signature Date