

Thank you for choosing our office. Because we care, we want to find out as much information as possible so we can render accurate treatment. Please fill out this confidential form completely. Thank You.

Patient Info:

Today's date: _____

Male
 Female Birth date _____ Age _____ E-mail _____

Name: Last _____ First _____ MI _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security _____ Employer _____ Occupation _____

Single Divorced
 Married Spouse Name _____ Widowed

Responsible Party: (For decision making if the patient is underage & also for payment)

(If different than patient listed above)

Relationship to patient _____

Name: Last _____ First _____ Middle _____ Suffix _____

Birth date _____ Social Security _____ E-mail _____

Address: Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Married Spouse Name _____
 Divorced (Only need info below if patient is a Dependent)
 Other Responsible Party Name _____

Address _____ Phone _____

Dental Insurance:

No Dental Insurance

Primary Insurance

Secondary Insurance

Ins. Co. _____ Ins. Phone _____ Name of Insured _____ Relationship to patient _____ SS# _____ DOB _____ ID # _____ Group # _____ Employer _____ Employer Phone _____	Ins. Co. _____ Ins. Phone _____ Name of Insured _____ Relationship to patient _____ SS# _____ DOB _____ ID # _____ Group # _____ Employer _____ Employer Phone _____
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Getting to know you:

How did you hear about us?

- I am an existing patient Sign Insurance
 Phone Book Newspaper Website
 AT & T-Yellow Pages
 Yellow Book-Yellow Pages
 Impact-Small Local Book

Did someone refer you to our office? No Yes Who can we thank? _____

Do we treat a family member? No Yes Who? _____

How would you like you appointment confirmed?? Email Text Phone call

~Please continue on reverse side~

Dental History:

Your last dental visit was _____ Last complete exam was _____ Was treatment completed? No Yes

Previous Dentist _____ Where? _____

My last x-rays were taken _____ May we contact them for your dental records? No Yes

Your Mouth:

What is the major reason you seek care at this time? _____

- Exam/Cleaning Pain Cosmetic Missing Teeth Infection
- Broken Teeth Dentures Color Bad Taste/Odor Orthodontics

Would you like to improve your smile? No Yes How? _____

How are your gums? Seem healthy Bleed occasionally Bleed Often Swollen

How is your ability to chew? Fine Limited Needs help

How are your teeth? Seldom hurt Sensitivity to hot/cold Pain to sweets Pain to chew

How is your jaw? Pops/clicks when moving Has locked open/shut Causes pain

*****I understand that patient names will be posted in our appointment books, on charts, and on schedules posted in treatment areas of the office and that patient privacy will be maintained as much as possible. I also understand that the staff of Eureka Smile Center may take photos of treatment that may be used in educational settings and professional teaching.**

Signed _____ Date _____

Medical History: Physicians Name: _____ Phone # _____

Females only

I am pregnant, may be, or am attempting to become so. Today's date: _____

How many weeks pregnant are you? _____ Physician _____

**NOTE: Some medications may cause changes in birth control or may affect the unborn baby.*

All Patients

Please check all that you have or have had in the past:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Jaw Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever Blister | <input type="checkbox"/> Pneumocystitis | |
| <input type="checkbox"/> Artificial Bone Year? _____ | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Psychiatric Therapy | |
| <input type="checkbox"/> Artificial Heart Valve Year? _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Therapy | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Therapy | |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack? Year _____ | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cancer – Chemo | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis A,B,C | <input type="checkbox"/> Sickle Cell Disease | |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid problems | |

Comments or any other illness we should know: _____

Do you consume a lot of grapefruit juice, grapefruits or grapefruit extract? No Yes

List of Current Medications: _____

Allergies: Have you had any allergies to any medications? No Yes

- Aspirin Penicillin Codeine Local Anesthetic Latex Metals Sulfa Drugs

Explain any past allergies: _____

By signing, I agree that the above information is correct & true.

X _____

Updates to History (Staff use only)

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Dr. Eric Klumb DDS
Dr. Mike Menolascino DDS

HIPAA Privacy Notice

Date: _____

Confidentiality Notice:

I, the patient or responsible party, understand all of the information provided to be accurately answered and I understand that it is my responsibility to notify **Eureka Smiles** of changes in any of the above information. I also realize that all of this information that I have provided is confidential and that none of the information here will be released to anyone without permission from the patient.

I authorize Eureka Smiles to discuss my dental records and treatment with:

_____ Relationship: _____

_____ Relationship: _____

Signature: _____

Parent/Legal guardian's signature if patient is under legal age

Dental Insurance Acknowledgement:

I, understand that dental insurance is an agreement between myself, the employee and the insurance company. Benefits change according to the plan between employee-employer insurance company relationships and **Eureka Smiles** can never be 100% sure of that coverage and/or benefits and are **NOT** responsible for them. **The patient or responsible party is ultimately responsible for all the fees not covered by insurance.** In the case of minors of separated or divorced parents, it is the responsibility of the parent bringing the patient into the office to arrange appointments and keep treatment and all accounts current.

Printed Name: _____

Signature: _____

Parent/Legal guardian's signature if patient is under legal age