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. Co._____
Ins. Phone_____	Ins. Phone_____
Name of Insured_____	Name of Insured_____
Relationship to patient_____	Relationship to patient_____
SS#_____ DOB_____	SS#_____ DOB_____
ID #_____Group #_____	ID #_____Group #_____
Employer_____	Employer_____
Employer Phone_____	Employer Phone_____

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:

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

Dr. Eric Klumb DDS
Dr. Mike Menolascino DDS
Dr. Jack D. Griffin Jr. DMD, MAGD

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