WELCOME TO OUR PRACTICE!

Jeffrey D. Eaton, D.D.S.
Rebecca E. Montgomery, D.D.S.

Please take a few minutes to answer the following questions so we can better assist you with your dental needs

PATIENT

Date _____ Soc. Sec.# _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency. who should we contact? _____ Phone _____

E-Mail Address _____ Cell _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber ID. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber ID. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays? _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply

- Bad Breath ❑
- Bleeding Gums ❑
- Blisters on Lips or Mouth ❑
- Finger Nail Biting ❑
- Grinding Teeth ❑
- Lip or Cheek Biting ❑
- Loose Teeth or Broken Filings ❑
- Orthodontic Treatment ❑
- Pain Around Ear ❑
- Periodontal Treatment ❑
- Sensitivity to Cold ❑
- Sensitivity to Heat ❑
- Sensitivity to Sweets ❑
- Sensitivity When Biting ❑
- Frequent Headaches ❑
- Jaw, Head or Neck Injuries ❑
- Jaw Difficulty: Clicking and/or Pain ❑
- Tooth Pain ❑

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	❑	❑
2. Ever had any serious illnesses or operations?	❑	❑
3. Are you currently taking any medication?	❑	❑

Please describe: _____

_____

_____

4. Do you use tobacco?	❑	❑
❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Chewing ____ Frequency		
5. Do you use alcohol?	❑	❑
Frequency: _____ Daily _____ Weekly		
6. Do you use cocaine or other drugs?	❑	❑
7. Do you wear contact lenses?	❑	❑

8. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (e.g. novocaine)	❑	❑
Penicillin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates (sleeping pills)	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Other	❑	❑

9. (Women Only) Are You:

Pregnant?	❑	❑
Nursing?	❑	❑
Taking birth control pills?	❑	❑

Please check all that apply:

- AIDS ❑
- Anemia ❑
- Anxiety/Depression ❑
- Arthritis, Rheumatism ❑
- Artificial Heart Valves ❑
- Artificial Joints ❑
- Asthma ❑
- Back Problems ❑
- Bleeding abnormally, with extractions or surgery ❑
- Blood Disease ❑
- Cancer ❑
- Chemical Dependency ❑
- Chemotherapy ❑
- Chronic Fatigue Syndrome ❑
- Circulatory Problems ❑
- Congenital Heart Lesions ❑
- Cortisone Treatments ❑
- Cough - persistent or bloody ❑
- Diabetes ❑
- Emphysema ❑
- Epilepsy ❑
- Fainting or Dizziness ❑
- Glaucoma ❑
- Headaches ❑
- Heart Murmur ❑
- Heart Problems ❑
- Hepatitis-Type ____ ❑
- Herpes ❑
- High Blood Pressure ❑
- HIV Positive ❑
- Jaundice ❑
- Jaw Pain ❑
- Latex Sensitivity ❑
- Kidney Disease ❑
- Liver Disease ❑
- Low Blood Pressure ❑
- Mitral Valve Prolapse ❑
- Nervous Problems ❑
- Osteoporosis ❑
- Pacemaker ❑
- Psychiatric Care ❑
- Radiation Treatment ❑
- Respiratory Disease ❑
- Rheumatic Fever ❑
- Scarlet Fever ❑
- Shortness of Breath ❑
- Sinus Trouble ❑
- Skin Rash ❑
- Stroke ❑
- Swelling of Feet/Ankles ❑
- Swollen Neck Glands ❑
- Thyroid Problems ❑
- Tonsillitis ❑
- Tuberculosis ❑
- Tumor or growth on head/neck ❑
- Ulcer ❑
- Venereal Disease ❑

ASSIGNMENT

I hereby authorize payment directly to Jeffrey D. Eaton, D.D.S., P.C. for all insurance benefits otherwise payable to me for services rendered, I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____