Patient Information 3

First Name *

Last Name *

MI

Preferred Name

Title

Gender *

Family Status *

Birthday *

/ /

MM DD YYYY

SSN

Drivers license

Address *

Street Address

Address Line 2 (Apartment number, Suite number, or Room number)

City

State / Province / Region

Postal / Zip Code

United States

Country

Home Phone

– –

Work Phone

– –

Mobile Phone

– –

Email *

Referred By

Student Status

School Name

Employment Status *

Appointment Preference

Communication Preferences

I receive emails

I receive mobile text

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Eaglesoft Medical History 2018

Patient First Name

Patient Last Name

Do you have, or have you had, any of the following?

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problems
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting Spells/Dizziness
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Trouble/Disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mitral Valve Prolapse
- [ ] Osteoporosis
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Psychiatric Care
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Renal Dialysis
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Spina Bifida
- [ ] Stomach/Intestinal Disease

- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice

Have you ever had any serious illness not listed above? *

○ No ○ Yes

Are there any emotional, behavioral, or sensory issues that we should be aware of prior to treatment? *

○ No ○ Yes

Are you under a physician's care now? *

○ No ○ Yes

Have you ever been hospitalized or had a major operation? *

○ No ○ Yes

Have you ever had a serious head or neck injury? *

○ No ○ Yes

Are you taking any medications, pills, or drugs? *

○ No ○ Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *

○ No ○ Yes

Are you on a special diet? *

○ No ○ Yes

Do you use tobacco? *

○ No ○ Yes

Do you use controlled substances? *

○ No ○ Yes

Women: Are you...

- [ ] Pregnant/Trying to get pregnant?
- [ ] Nursing?
- [ ] Taking oral contraceptives?

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics

Other? *

○ No ○ Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Dental History

Patient First name *

Patient Last Name *

Why you are changing dentist?

- [ ] Change of residence
- [ ] Change of dental plan
- [ ] Your office is closer
- [ ] My dentist retired/closed
- [ ] Unhappy
- [ ] Too expensive
- [ ] You were recommended
- [ ] Other

Please explain

How long since the last visit to dentist? *

- [ ] 1 month
- [ ] 3 months
- [ ] 6 months
- [ ] 1 year
- [ ] 2 years
- [ ] 3 or more years
- [ ] I've never seen a dentist

Reason for the visit *

- [ ] Check-up
- [ ] Cleaning
- [ ] Pain
- [ ] Other

Please provide details

Have you ever had a bad experience at the dentist *

- ◯ No
- ◯ Yes

Have you had any complications following dental treatment? *

○ No ○ Yes

Have you had unfavorable reaction to dental anesthetic? *

○ No ○ Yes

Does dental treatment make you nervous? *

○ No
○ Yes, Slightly
○ Yes, Moderately
○ Yes, Extremely

Are your teeth sensitive to cold, hot? *

○ No ○ Yes

Do your gums bleed when you brush or floss? *

○ No ○ Yes

Do you grind your teeth? *

○ No ○ Yes

Are you aware of sores or irritated areas in the mouth? *

○ No ○ Yes

Have you ever been treated for Periodontal Disease? *

○ No ○ Yes

How often do you brush? *

○ Once a day
○ Twice a day
○ Three times a day
○ Every time I eat

How often do you floss? *

○ Never
○ Occasionally
○ Once a day
○ Twice a day
○ Three times a day
○ Every time I eat

Do you like your smile? *

○ No ○ Yes

If you could change your smile, what would you like to change?

☐ The color of my teeth
☐ Close spaces or restore worn and broken teeth
☐ The shape of my teeth
☐ The position or alignment of my teeth
☐ Other

If Other please specify

I am interested in *

☐ Teeth whitening
☐ Cosmetic evaluation
☐ Replacement of missing teeth
☐ Straight teeth
☐ Sedation
☐ White fillings
☐ Home care
☐ Breath control
☐ Other

If Other please specify

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about

HIPAA Acknowledgement Form

Patient First Name *

Patient Last Name *

Relationship to the patient *

Name if not the patient *

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

-Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link HIPAA Notice of Privacy Practicesor in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Stutler Dental has the right to change its Notice of Privacy Practices from time to time and that I may contact Stutler Dental at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Stutler Dental restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Stutler Dental is not required to agree to my requested restrictions, but if Stutler Dental does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Stutler Dental has taken action relying on this consent.

By checking the box I acknowledge that *

- [ ] I received and read this organizationNotice of Privacy Practices

Please sign *

Clear

Consent for Internet Communications

First Name *

Last Name *

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deaivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentially that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the term of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

By checking the box I acknowledge that *

- [ ] I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.