WELCOME TO ECKMAN FAMILY DENTISTRY
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

ADULT PATIENT INFORMATION
(and account responsibility)

NAME_____
Address_____
City/State/Zip_____
Home Phone_____
Business Phone_____
Cell Phone #_____
DATE OF BIRTH_____Sex:___ Male ___Female
Social Security#_____
Marital Status___S___M___D___W
Do you have children?___Yes___No
Payment Method ___Cash___Check___Visa
___MasterCard___Discovery___AMX
Who may we thank for referring you to our office?

_____
Their address_____

DENTAL INSURANCE INFORMATION

Subscriber Name_____
Social Security #_____
Date of Birth_____
Employer_____
Address_____

Business Phone_____
Your relationship to the insured
___Self___Spouse___Child

DENTAL INSURANCE COMPANY

Name_____
Address_____
Group Number_____
Agreement Number_____

FOR SECONDARY INSURANCE ONLY

Subscriber Name_____
Social Security #_____
Date of Birth_____
Employer_____
Address_____

SECOND DENTAL INSURANCE COMPANY

Name_____
Address_____
Group Number_____
Agreement Number_____

CHILD PATIENT INFORMATION

NAME_____
Sex:___Male___Female
DATE OF BIRTH_____
Age_____ Grade_____
School_____
Social Security #_____
Address and phone if different_____

_____
Age at first dental visit_____
Pediatrician_____
General Health_____
Allergies_____
To penicillin?_____
To other drugs?_____

PATIENT HEALTH INFORMATION

When was the last time you had your teeth cleaned:_____
Family Physician_____
Are you in good health:_____
Are you under a physician's care now?_____
If yes, why"_____
List any medications you are taking now:_____

Do you smoke:___yes___no
Do you have a condition which requires premedication?_____
Do you have a prosthesis?_____
Allergy to penicillin?_____
Allergy to other drugs?_____
Reaction to anesthetic?_____
Are you bothered by:
_____Frequent headaches
_____Ringing of the ears
_____Clicking
_____Dizziness
Have you ever had:
_____Orthodontic treatment
_____Periodontal treatment
_____Mouth or head injury

FOR WOMEN ONLY: Are you…
_____Pregnant _____months
_____Nursing a baby
_____Taking birth control pills

PERSONAL MEDICAL HISTORY – Please check (X) if you have or have had:

__rheumatic fever	__stroke	__glaucoma	__ulcers	__hemophilia
__high blood pressure	__artificial joints	__cataracts	__cancer	__sickle cell disease
__heart condition	__epilepsy or seizures	__eye implants	__hepatitis A or B	__bruise easily
__mitral valve prolapse	__emphysema	__tuberculosis	__venereal disease	__liver disease
__chronic cough	__asthma	__AIDS	__thyroid disease	__artificial heart valve
__hayfever	__HIV positive	__kidney trouble	__pacemaker	__diabetes
__herpese	__blood transfusion			

PATIENT/PARENT SIGNATURE _____ DATE_____
HISTORY REVIEW / DOCTOR SIGNATURE_____ DATE_____