Patient Infor	mation			
Name: Last First MI	Preferred Name:			
Male Female Married Single Child	Spouse's Name:			
Social Security:	Birth Date:			
Address:				
Street	Apt.			
City	State Zip Code			
Phone (H): (W):	(Mobile):			
Occupation:Employer Name:	How long?			
Emergency Contact:	Phone:			
How did you find out about us?				
Policies (Please read carefully)				
Our dental office has chosen to not take assignment of insurance benefit. We are instead requesting that the insurance company send the benefit check directly to you. Therefore, in consideration of the professional services that are rendered, we ask that patients pay the charges in full at the time of treatment. As a courtesy, we will provide you with a completed American Dental Association insurance form at each visit for you to mail. Usually, the patient will receive the benefit check within 30 days and all balances are paid. We will be available to assist you in any way should questions or problems arise with your claim. Thank you in advance for your assistance.				
For most non-routine treatments, our office will provide you with a written treatment plan prior to treatment. This treatment plan will list possible treatments as well as the fee estimates for these treatments. These fee estimates/proposals can only be extended for a period of six (6) months from the date of the treatment plan.				
If you are unable to keep an appointment for any reason, please notify our office at least 24 hours in advance so that we may have enough time to reappoint. If broken appointments repeatedly occur, it may be necessary to charge a broken appointment fee of \$40. Thank you for your understanding.				
I have read the above policies, understand them, and agree with their content.				
Signed:Patient/Parent/Guardian	Date			

Responsible Party (if different)				
Name	of Res	sponsible Party: Last First MÌ		
Social Security: Birth Date:				
Addre				
Phone	e (H):	(W): (Mobile):		
	0	PTIONAL: Insurance Information (to be printed on your claim form as a courtesy)		
Policy		p Number:		
Place	of Em	ployment (if through company)		
Insurance Company:				
ms. C	o. Auc	mess		
Ins. Co. Phone:				
		Dental History (Please circle the answers that apply)		
		2 ontail History (Trease effect the answers that apply)		
YES	NO	Have you ever had a severe toothache?		
YES	NO	Have you ever had a broken tooth or filling?		
YES	NO	Have you ever had gum treatment or been told you have a gum problem?		
YES	any existing condition?			
YES	NO	, and a second of the second o		
YES NO Are any of your teeth currently sensitive to hot, cold, or biting pressure? If yes, which?				
YES	NO	Do you have any pain, swelling, bleeding associated with your gums? If yes, which?		
YES	NO	Are you having any problems chewing your food?		
YES	NO	Are you having any problems with your jaw joints?		
YES YES	NO NO	Are you grinding or clenching your teeth at night or when you feel stress?		
IES	NO	Have you received regular dental care throughout your life? If not, please explain		
YES	NO	If not, please explain Are you nervous or anxious about receiving dental treatment?		
YES	NO	Are you satisfied with the appearance of your teeth?		
		If not, please explain		
Whon	XX/0.0 X/	our last dontal visit? What was done?		
Anvo	was y other co	our last dental visit? What was done? omments regarding your dental treatment or history:		
W.J. Z. 2017 - 1979				
To the	e best o	of my knowledge, all of the proceeding answers and information provided are true and correct.	8	
Signed:				
	Pa	tient/Parent/Guardian Date		

Patient Name:

X

Timothy D Sims, DDS, PA Eaglesoft Medical History

Birth Date:

Date Created:

57 4 1 Alice

Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c Are you under a physician's care now? OYes ONo If yes Have you ever been hospitalized or had a major operation? OYes ONo If yes Have you ever had a serious head or neck injury? ○Yes ○No If yes Are you taking any medications, pills, or drugs? OYes ONo If yes Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If yes Have you ever taken Fosamax, Boniva, Actonel or any other OYes ONo If yes medications containing bisphosphonates? Are you on a special diet? ○Yes ○No Do you use tobacco? ○Yes ○No Do you use controlled substances? ○Yes ○No If 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? Do you have, or have you had, any of the following? AIDS/HIV Positive ○Yes ○No Cortisone Medicine OYes ONo Hemophilia OYes ONo Radiation Treatments OYes ONo Alzheimer's Disease OYes ONo Diabetes OYes ONo Hepatitis A ○Yes ○No Recent Weight Loss OYes ONo Anaphylaxis ○Yes ○No Drug Addiction OYes ONo Hepatitis B or C ○Yes ○No Renal Dialysis OYes ONo Anemia ○Yes ○No Easily Winded ○Yes ○No Herpes OYes ONo Rheumatic Fever OYes ONo Angina ○Yes ○No Emphysema OYes ONo High Blood Pressure OYes ONo Rheumatism OYes ONo Arthritis/Gout ○Yes ○No Epilepsy or Seizures OYes ONo High Cholesterol OYes ONo Scarlet Fever OYes ONo Artificial Heart Valve ○Yes ○No Excessive Bleeding OYes ONo Hives or Rash OYes ONo Shinales ○Yes ○No Artificial Joint ○Yes ○No Excessive Thirst ○Yes ○No Hypoglycemia OYes ONo Sickle Cell Disease OYes ONo Asthma OYes ONo Fainting Spells/Dizziness OYes ONo Irregular Heartbeat ○Yes ○No Sinus Trouble OYes ONo Blood Disease ○Yes ○No Frequent Cough OYes ONo Kidney Problems ○Yes ○No Spina Bifida ○Yes ○No Blood Transfusion OYes ONo Frequent Diarrhea Leukemia OYes ONo ○Yes ○No Stomach/Intestinal Disease OYes ONo Breathing Problems OYes ONo Frequent Headaches ○Yes ○No Liver Disease ○Yes ○No Stroke ○Yes ○No Bruise Easily OYes ONo Genital Herpes OYes ONo Low Blood Pressure OYes ONo Swelling of Limbs OYes ONo Cancer OYes ONo Glaucoma ○Yes ○No Lung Disease ○Yes ○No Thyroid Disease OYes ONo Chemotherapy ○Yes ○No Hav Fever ○Yes ○No Mitral Valve Prolapse OYes ONo Tonsillitis OYes ONo Chest Pains OYes ONo Heart Attack/Failure OYes ONo Osteoporosis OYes ONo Tuberculosis ○Yes ○No Cold Sores/Fever Blisters OYes ONo Heart Murmur ○Yes ○No Pain in Jaw Joints OYes ONo Tumors or Growths ○Yes ○No Congenital Heart Disorder OYes ONo Heart Pacemaker OYes ONo Parathyroid Disease OYes ONo Ulcers ○Yes ○No Convulsions OYes ONo Heart Trouble/Disease ○Yes ○No Psychiatric Care ○Yes ○No Venereal Disease ○Yes ○No Yellow Jaundice OYes ONo Have you ever had any serious illness not listed above? OYes ONo Comments: Variable for 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. Signature of Patient, Parent or Guardian: