Welcome

131 Commons Court Chadds Ford, PA 19317
Phone: 610.558.1977 Fax: 610.558.4980
www.EunsonDental.com
Email:Smiles@EunsonDental.com

TODAY'S DATE ______________________

PATIENT NAME:
☐Mr. ☐ Ms. ☐ Rev.
☐Mrs. ☐ Dr. ____

LAST **FIRST** **MI** **PREFERRED NAME**

ADDRESS____
STREET **APT #** **CITY** **STATE** **ZIP CODE**

PHONE #: HOME ______________________**WORK** ________________________ **CELL** ________________________**TEXT OK?** ☐ Y ☐ N

Where is the best place to call you? ☐ Home ☐ Work ☐ Cell **Can we leave a message on your answering machine?** ☐ Y ☐ N

How would you prefer we remind you about your check up appointment (usually every 6 months)? ☐ Email ☐ Text

SS#: _______________________________________ **EMAIL ADDRESS**: ____

Gender: ☐ M ☐ F **AGE** _____ **DOB**: ______________**Marital Status**: ☐Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER/SCHOOL: _______________________________________ **OCCUPATION:** ____________________ **If student, full time?** ☐ Y ☐ N

Do you have access to a flexible spending account through anyone in your household that you'd like to use? ☐ **Y** ☐ **N**

How did you find out about our office? Tracking our marketing reduces our costs and therefore, your fees. All feedback welcome!!

☐ Chadds Ford Live ☐ Yellow Pages ☐ Our Website ☐ Insurance Website ☐ Main Line Today Top Dentist Article

☐ Google ☐ Yahoo! ☐ Bing ☐ Other search engine ☐ Online Ad ____
(DO YOU REMEMBER WHICH SITE WERE YOU USING?)

☐Friend ____ ☐ OTHER ____
NAME PLEASE (SO WE MAY SEND THEM A THANK YOU GIFT) (PLEASE LIST

IN THE EVENT OF AN EMERGENCY, WHO SHOULD BE NOTIFIED? <u>(Someone OTHER than in your household)</u>

NAME: _______________________________________ PHONE____________________________ RELATIONSHIP______________________

SPOUSE INFORMATION OR IF CHILD, PARENT INFORMATION

HIS/HER NAME____ SS# ____

EMPLOYER: ________________________________ WORK PHONE____________________________ BIRTH DATE____________________

<u>IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING</u>

QUESTIONS APPLY TO SUBSCRIBER (<u>EMPLOYEE</u>)

SUBSCRIBER: ____ **PATIENT RELATIONSHIP TO INSURED?** _________________________

DOB: _______________ **SS#** _____________________________ **POLICY ID #** _______________________________ **GROUP #** __________________

EMPLOYER __________________________________ **EMPLOYER ADDRESS** ____

INSURANCE COMPANY:____ **INS CO PHONE #:** ______________________________

MEDICAL HISTORY

Physician name: ______________________ Phone/**Town:** ______________________

Approximate date of last physical: ______________________ **Your current health is:** ☐Excellent ☐ Good ☐ Fair ☐ Poor

Are you under care of a physician for any condition? ☐Yes ☐No If so, please explain: ______________________

Please list any medication, herbal supplements or vitamins that you currently take including the dosage and frequency: ______________________

____

Please list any other medications taken over the last 2 years not listed above ______________________

Have you ever been, under treatment for Osteoporosis? ☐Yes ☐No **Have you GAINED or LOST 10 or more pounds over the last year?** ☐Y ☐N

Have you ever taken any of the following medications: Plavix Coumadin Warfarin Asprin (daily) Prolia Xgene

Pradaxa Fosamax Eliquis Bonivia Actonel Zometa Xarelto

Have you been hospitalized during the past 5 years? ☐Y ☐N If so, for what? ______________________

Do you smoke or use chewing tobacco? ☐Y ☐N If so, how much per day? __________ Per week? __________ Per year? __________

FEMALE PATIENTS ONLY

Are you pregnant or is there any possibility you are at this time? ☐ Y ☐ N If so, due date: __________

Do you take oral contraceptives (birth control pills)? ☐Y ☐N Are you nursing? ☐Y ☐N

Have you ever had any of the following medical problems or diseases? <u>Please circle YES or NO to each question.</u>

Y N Heart Attack Year: __________
Y N Angina/Chest Pain
Y N Rheumatic Fever
Y N Heart Surgery
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Congenital Heart Lesion/Defect
Y N Bacterial Endocarditis
Y N Pacemaker / Defibrillator
Y N Artificial Heart Valves
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Hemophilia
Y N Excessive Bleeding
Y N Sickle Cell Anemia
Y N Stroke What Year: __________
Y N Kidney Problems
Y N Dialysis

Y N Hepatitis / Type: __________
Y N Liver Problems/Jaundice
Y N Diabetes: Type I / Type II
Y N Tuberculosis (Tb)
Y N Asthma
Y N Emphysema / COPD
Y N Shortness of Breath
Y N Hay Fever/Seasonal Allergies
Y N Frequent Headaches
Y N Glaucoma
Y N Parkinson's Disease
Y N Epilepsy and/or Seizures
Y N Multiple Sclerosis
Y N Thyroid Problems
Y N Tumors / Growths
Y N Chemotherapy
Y N Radiation Therapy
Y N Cancer Type: __________

Y N Any Artificial Replacements? (Knee, Hip, Joints, Pins, Plate) What Year: __________
Y N Rheumatism/Arthritis
Y N Cortisone Medication or Injection
Y N Lupus
Y N Sjogren's Syndrome
Y N Osteoporosis/Osteoporosis treatment
Y N Fibromyalgia
Y N Acid Reflux/GERD
Y N Colitis/Irritable bowel syndrome (IBS)
Y N Gastric Bypass Surgery
Y N Sexually Transmitted Disease (STD)
Y N HIV Positive/AIDS
Y N Drug/Alcohol Abuse
Y N Psychiatric Problems
Y N Other: __________

Y N Have You Had an Organ Transplant? Type: ______________________ Year: __________
Y N Have You Ever Donated an Organ/Tissue? Type: ______________________ Year: __________

Are you allergic (hives or rash) to or have you had an adverse reaction to any of the following?

Y N Penicillin
Y N Amoxicillin
Y N Erythromycin
Y N Clyndamycin

Y N Aspirin
Y N Codeine
Y N Valium
Y N Xanex

Y N Motrin/Ibuprophen
Y N Epinephrine
Y N Tylenol/Acetominophen
Y N Aleve/Naproxen

Y N Jewelry or Metal (Gold, Nickel, Silver, etc.)
Y N Latex/Plastic
Y N Anesthetics/Novocaine
Y N Other: __________

I understand the above information is necessary to provide me/my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Guardian Signature: ______________________ **Date:** __________

DENTAL HISTORY

Previous Dentist/Location:____ **Last exam/cleaning:** ___________________________

Date of last FULL set of x-rays? ____________ **Why did you come to the dentist today?** ____

Your current dental health is? ☐Good ☐Fair ☐Poor **Do you want to save your natural teeth?** ☐Yes ☐No

Are you currently in pain/discomfort? ☐Yes ☐No **Are any of your teeth loose?** ☐Yes ☐No

Do you have any sensitivity to: ☐None ☐Hot ☐Cold ☐Sweets ☐Biting ☐ Other: ____

Do you like your smile? ☐Yes ☐No **Please CIRCLE the MOST important features in your smile that you would like to CHANGE.**

Color Shape Alignment Length Gaps Crowding Gum Display Nothing, I'm happy Other: ____________________

Please CIRCLE the values that are MOST important to you about your smile.

Esthetics Comfort Longevity Function Long Term Cost Effectiveness

Does food frequently get stuck between your teeth? ☐Yes ☐No If so, where? ____

Do you bite your lips/cheeks frequently? ☐Yes ☐No **Do you have difficulty eating or swallowing?** ☐Yes ☐No

Do you have dry mouth? ☐Yes ☐No **Have you noticed a change in your speech or sound of your voice?** ☐Yes ☐No

Have you ever responded adversely to medical/dental treatment? ☐ Y ☐ N If so, how? ____

Did any dentist ever recommend treatment that was never performed? ☐ Y ☐ N If yes, what type of work was it? _______________________

Why wasn't work completed? ____

Do you experience pain/discomfort/clicking in your jaw? ☐Yes ☐No **Do you grind or clench your teeth?** ☐Yes ☐No

Have you had any previous injuries/surgery to your face or jaw? ☐Yes ☐No If so, please list _______________________________________

Do your gums ever bleed during brushing? ☐Yes ☐No **During flossing?** ☐Yes ☐No

How often do you floss? ☐Daily ☐Weekly ☐Monthly ☐Never **How often do you brush?** ________ Times/Day

Have you ever had gum/periodontal treatment or disease? ☐Yes ☐No If yes, when? ____

What bristles do you use on your toothbrush? ☐Hard ☐Medium ☐Soft ☐Extra Soft **Do you use a manual or electric tooth brush?** (circle one)

Do you experience stress/anxiety when you visit a dental office? ☐Yes ☐No

Do you normally have regular dental visits (2 times/year)? ☐Yes ☐No **Did you ever wear braces?** ☐Yes ☐No

Is there anything else about having dental treatment that you would like us to know? ☐Yes ☐No If yes: _______________________________

____

____

I understand the above information is necessary to provide me/my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Guardian Signature: ____ Date: ____________________

PATIENT / PARENT / GUARDIAN CONSENT

Consent:
You are requested to read the following paragraphs and to sign your name in the appropriate place if you consent to treatment of yourself by Dr. Anne Eunson or her staff at Eunson Family & Cosmetic Dentistry.

1. I have received the Notice of Privacy Practices and I have had the opportunity to review it.

2. I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

3. I also authorize doctor to perform all recommended operations, procedures, techniques, and/or treatment mutually agreed upon by me and doctor, and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Eunson choose and employ such assistance as deemed fit to provide recommended treatment.

4. I understand this consent will remain in force until I revoke it in writing.

5. I hereby state that I have read and understand this consent form, and that I have been given the opportunity to ask questions, I might have, and that all my questions have been answered in a satisfactory manner.

6. ASSIGNMENT OF BENEFITS: I hereby assign dental insurance benefits to which I may be eligible for my dental care to cover the costs of the care and treatment rendered to myself or my dependent for treatment rendered by Dr. Eunson and her staff. I understand that I am responsible for any and all charges not covered by my insurance plan.

Patient/Guardian Signature: ____ Date:______________________

Release of Information – We respect your right to privacy; However, oftentimes it is useful to have family or a trusted friend help with your treatment and financial options. Please make your choice below:

☐ I authorize the release of my information including diagnosis, records, examination, radiographs, photos treatment plans or anything else that would be helpful in providing my dental care. This information may be released to:

( ) Spouse ____

( ) Child(ren) ____

( ) Parent(s) ____

( ) Other ____

☐ Information is not to be released to anyone.

This **Release of information** will remain in effect until terminated by me in writing.

Patient/Guardian Signature:____Date:_______________________

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify) ______________________________________

Office Policy

We have established the following policies to better serve our family of patients. When observed, these policies will allow us to provide you with the following benefits:

- We will be able to stay on schedule and see patients at their appointed times.
- We will be able to offer appointments when you want them, even on short notice.
- We can better accommodate people with busy and unpredictable schedules.

Please check each box to indicate you have read and understand these policies.

Cancelled/Missed Appointments

☐ I understand that I must give notice of at least 2 business days if I must cancel an appointment. We understand that emergencies do arise and that notice of 2 business days may not be possible. Please do your best to inform us as soon as possible.

☐ I understand that if an appointment is missed without prior notice I may be charged $40 per half hour for a scheduled appointment. If I am more than 15 minutes late for an appointment, it may not be possible to be seen that day and I will be charged $40 per half hour of your scheduled appointment.

Financial Policy

Payment in full is due at the time of service unless arrangements are made in advance. We accept cash, check, debit card or credit card (VISA, Master Card and Discover Card.)

We will gladly accept assignment of benefits for your insurance if:

a. We have all necessary insurance information to confirm your benefits prior to your first appointment. It is your responsibility to advise us of any future changes.

b. Estimated patient co-payments and deductibles are paid at the time of service.

c. Your insurance company will assign benefits to us. Occasionally, insurance companies will not send their payment directly to our office. In this case, you are responsible for paying the office. We will submit your claims and payment will be sent directly to you, often within 30 days.

Payment Options

Any of the following options must be arranged in advance to your appointment:

Payment of the estimated co-pay at the time of service. While we will do our best to accurately estimate your portion, we do not have control of your insurance company policies. ULTIMATELY, ANY CHARGES FOR SERVICES PROVIDED ARE YOUR RESPONSIBILITY, REGARDLESS OF DENTAL INSURANCE BENEFITS.

If a procedure involves multiple visits, ½ of the patient's payment is due at the start of treatment. The remaining balance can then be divided over your remaining appointments. FINAL PAYMENT DUE PRIOR TO COMPLETION OF TREATMENT.

If you need to extend payments for your treatment, financing through Care Credit is available. This enables 6-12 months of interest free payment. This option requires payment of your estimated charges when treatment is initiated. Please ask us for more details.

By signing this, you acknowledge that you've read and understand our office policies.

Patient/Guardian Signature: ____ Date: _________________________

Responsible Party Signature:____ Relationship: ___________________________________