S. WARD ECCLES
D.D.S.
INCORPORATED

PATIENT INFORMATION

Name _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Last Name First Name Middle Name

Nickname _____ Birthdate ____/____/____ SS# ____-____-____

Mailing Address _____
Street City State Zip

Sex: M / F **Email Address** _____

Phone (____) _____ C ❒ H ❒ Work Phone (____) _____

Occupation _____

Referred by a patient? ☐ Yes ☐ No If Yes, whom may we thank? _____

If No, how did you find us? _____ Marital Status: _____

Spouse's Name _____ Occupation _____

Employer _____
Company Street City State Zip

Is Patient allergic to any medications? ☐ Yes ☐ No List _____
Is Patient allergic to latex? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Caregiver/other

Name _____ Mr./Mrs./Miss/Ms.
Last Name First Name Middle Name

Mailing Address _____
Street City State Zip

Phone (____) _____ C ❒ H ❒ Work Phone (____) _____

Employer _____

*Social Security No. _____ *Drivers License No. _____

INSURANCE INFORMATION

Insurance Company #1 _____

Insurance Company #1 Address _____

Policyholder _____ Birthdate _____ SS# or ID# _____ Group#_____

Insurance Company #2 _____

Insurance Company #2 Address _____

Policyholder _____ Birthdate _____ SS# or ID# _____ Group#_____

EMERGENCY NOTIFICATION

Nearest relative not living with you _____
Name Telephone Relationship

CONSENT: The undersigned hereby authorizes Dr. Eccles to take x-rays, study models, photographs, or any other diagnostic aids appropriate by Dr. Eccles to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Eccles to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for my dependents or myself is mine due and payable at the time services are rendered. I further understand that a carrying charge of 18% will be added to any overdue balance. I also assign all insurance benefits to Dr. Eccles.

Responsible Party Signature _____ **Date** _____

DENTAL HISTORY QUESTIONNAIRE

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs.

Previous Dentist _____ Specialty _____

Period of Treatment _____ Date of last visit _____

Address _____
Number Street City CA Zip (Area Code) Phone number

Last full mouth x-rays _____ Last complete dental exam _____

What is your immediate dental concern? _____

_____

Please answer the following questions.

Are you presently in pain? …… ☐ Yes ☐ No
☐ Teeth ☐ Jaw ☐ Gums ☐ Face ☐ Eyes ☐ Ears ☐ Other _____

Is any part of your mouth sensitive to the following: …….. ☐ Yes ☐ No
☐ Hot ☐ Cold ☐ Pressure ☐ Chewing / Biting down
☐ Sweet ☐ Sour ☐ Other _____

Have you been advised to take prophylactic antibiotics before dental treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TM)? …… ☐ Yes ☐ No

Have you had any injuries or trauma to face, head, and/or neck? …… ☐ Yes ☐ No

Have you been told you have gum problem or diagnosed with Periodontal Disease? …… ☐ Yes ☐ No

If YES, When? _____ Completed Treatment? _____

Do you notice the following regarding your smile? …….. ☐ Yes ☐ No
☐ Dry Mouth ☐ Bad Taste/Odor ☐ Food Catches Between Teeth
☐ Growth or Swelling ☐ Stiff or Tired Jaw ☐ Gums Bleed When Brushing
☐ Clenching (AM/PM) ☐ Jaw Popping/Clicking ☐ Frequent sores (cheeks, lips)
☐ Grinding (AM/PM) ☐ Denture or Appliance ☐ Have Dental Implants

Are you dissatisfied with the appearance of your teeth? …… ☐ Yes ☐ No

If yes, what would you most like to change? Whitening? Crooked teeth? _____

_____

Is snoring a concern to your or a family member? …….. ☐ Yes ☐ No

Have you ever been told you have sleep apnea? …… ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? …….. ☐ Yes ☐ No

If so, please provide details (approx. date, whom, what happened) _____

_____

MEDICAL HISTORY QUESTIONNAIRE

Thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

Family Physician _____ Date of last visit _____

Specialty _____

Address _____
Number Street City State Zip (Area Code) Phone

Please answer the following questions.

Do you have a current medical problem? …… ☐ Yes ☐ No
Are you currently under the care of a physician? …… ☐ Yes ☐ No
Are you taking any prescriptions/over the counter drugs? (please provide list) …… ☐ Yes ☐ No
Have you been hospitalized or had a serious illness within the past 5 years? ……... ☐ Yes ☐ No
Have you ever taken any of the following diet drugs? (Pondimin, Redux, Phen-Fen) …….. ☐ Yes ☐ No
Do you have any metal rods, pins, or implants? …… ☐ Yes ☐ No

Have you been diagnosed to have any of the following conditions or problems?

Abnormal Bleeding / Hemophilia	☐ Y ☐ N	Difficulty Breathing	☐ Y ☐ N	Mental Disability	☐ Y ☐ N
ADHD/Learning Impairment	☐ Y ☐ N	Drug Reaction	☐ Y ☐ N	Mitral Valve Prolapsed	☐ Y ☐ N
AIDS/HIV	☐ Y ☐ N	Endocrine	☐ Y ☐ N	Mouth Breathing	☐ Y ☐ N
Alcohol / Drug Abuse	☐ Y ☐ N	Epilepsy / Seizures	☐ Y ☐ N	Nervous System	☐ Y ☐ N
Anemia	☐ Y ☐ N	Eye / Vision	☐ Y ☐ N	Nose / Sinus Problems	☐ Y ☐ N
Angina / Chest Pains	☐ Y ☐ N	Fainting Spells	☐ Y ☐ N	Nutritional Deficiency	☐ Y ☐ N
Arthritis / Joint Disease	☐ Y ☐ N	Fibromyalgia / Chronic Fatigue	☐ Y ☐ N	Pacemaker	☐ Y ☐ N
Asthma	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Polio	☐ Y ☐ N
Atrial Fibrillation	☐ Y ☐ N	Gastrointestinal	☐ Y ☐ N	Pregnant / Nursing	☐ Y ☐ N
Autism	☐ Y ☐ N	Hearing	☐ Y ☐ N	Psychiatric Condition	☐ Y ☐ N
Autoimmune Disease	☐ Y ☐ N	Heart Attack / Surgery / Lesions	☐ Y ☐ N	Rheumatic / Scarlet Fever	☐ Y ☐ N
Blood Pressure (High / Low)	☐ Y ☐ N	Heart Disease / Atherosclerosis	☐ Y ☐ N	Shingles	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Sickle Cell Disease / Traits	☐ Y ☐ N
Bone / Orthopedic	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Skin / Eczema	☐ Y ☐ N
Bronchitis / Sore Throat	☐ Y ☐ N	Herpes / Fever Blisters	☐ Y ☐ N	Spina Bifida	☐ Y ☐ N
Cancer / Tumor	☐ Y ☐ N	Joint Replacement	☐ Y ☐ N	Stroke / Brain Injury	☐ Y ☐ N
Candida	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Cerebral Palsy	☐ Y ☐ N	Leukemia / Lymphoma	☐ Y ☐ N	Tonsils / Adenoids	☐ Y ☐ N
Chemotherapy / Radiation	☐ Y ☐ N	Liver Disease / Jaundice	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Colitis	☐ Y ☐ N	Lung / Pneumonia	☐ Y ☐ N	Ulcers (Stomach / Intestinal)	☐ Y ☐ N
Congenital Heart Defect	☐ Y ☐ N	Lupus	☐ Y ☐ N	Venereal Disease / STD	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Lyme Disease	☐ Y ☐ N	Whooping Cough / Mumps	☐ Y ☐ N

If yes, please explain: _____
_____
_____

Are you allergic to or have you had any unusual reaction to any of the following medications? …….. ☐ Yes ☐ No

☐ Local anesthetics ☐ Novocain ☐ Epinephrine ☐ Nitrous Oxide
☐ Penicillin ☐ Erythromycin ☐ Sulfa Drugs ☐ Other antibiotics _____
☐ Xylocaine ☐ Codeine ☐ Aspirin ☐ Barbiturates
☐ Sleeping pills ☐ Any other allergies? _____

☐ Alcohol ( ) drinks per day ☐ Tobacco ( ) packs per day for approximately _____ years
☐ "Recreational" drugs such as cocaine, marijuana, stimulants, or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with Dr. Eccles. _____
_____

Is there any other medical information that you feel Dr. Eccles should know about? _____
_____

To the best of my knowledge, all answers are true and correct. If I have any change in my health or medications, I will inform Dr. Eccles at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

_____
Patient or Guardian Signature

CONSENT & ACKNOWLEDGEMENT OF RECEIPTS

In effect: _____ (today's date) until further notice.

Purpose of Consent: To ensure clear communication between patient (and guardian), office staff and the doctor. Clear communication is important to us. Our goal is to make sure all parties are comfortable with their visits and all components of the visit have been explained thoroughly. The following policies, procedures, and practices apply to our office. Please, take the opportunity to read each handout. This one-page form is to document that you have been informed. Our office policies and procedures and privacy practices can always change as are available upon request. These forms can be downloaded from our website via the New Patient Page.

OFFICE POLICIES AND PROCEDURES

Purpose of Agreement: By signing this form, you consent to appointment, financial, and accompany minor policies and practices.
Notice of Office Policies and Procedures: You have the right to read our Office Policies and Procedures before you decide to become a patient of our office. The policies and procedures establish a clear understand of how our appointments work, how we bill insurance as a courtesy (except in the case of Delta Dental PPO and Premier plans, as we are in-network), and financial responsibility. A copy of our policies accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our practices as described in our Office Policies and Procedures. If we change our practices, we will issue a revised Office Policies and Procedures, which will contain all changes.

_____ (Initials) I have receipted a copy of the "Office Policies and Procedures." I have had full opportunity to read and consider the contents of the consent form. I further acknowledge I have received a copy of Office Policies and Procedures.

HIPPA PRIVACY PRACTICES

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment payment activities, and healthcare operations, of the uses and discloses we may make of your protected health information, and of other important matters about your protected health information. A copy of our notices accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain all changes. This may apply to any of your protected health information that we maintain.
Right to Revoke: You have the right to revoke this consent at any time by providing a written notice of your revocation. Please note that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decide to treat you or discontinue to treat you if you revoke this consent.

_____ (Initials) I have receipted a copy of the "HIPPA Privacy Practices." I have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I further acknowledge I have received a copy of your Notice of Privacy Practices.

DENTAL MATERIALS FACT SHEET

_____ (Initials) I have receipted a copy of the "Dental Materials Fact Sheet." I have had full opportunity to read and consider the contents of the fact sheet. I further acknowledge that I have reviewed the Dental Materials Fact Sheet of the California Dental Association.

Signature: _____ Today's Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following

Representative's Name: _____ Relationship: _____

FOR PRACTICE USE ONLY

We attempted to obtain written acknowledgement and consent of our Office Policies and Procedures, Notice of Privacy Practices, and Dental Materials Fact.
Sheet, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____