# S Ward Eccles, DDS, Inc.

## Biological Dentistry

## NEW PATIENT IN-TAKE FORM

### Demographic Information

**First:**

**Middle:**

**Preferred:**

**Last:**

**Gender:** ☐ Female ☐ Male

**Birthdate:**

**Social Security Number:**

**Drivers License:**

**Address 1:**

**City:**

**State/Province:**

**Address 2:**

**Zip Code/Postal Code:**

### Contact Information

**Preferred Contact Method:**

☐ Phone ☐ Text ☐ Email

**Cell Phone :**

**Email Address:**

**Emergency Contact Name:**

**Emergency Contact Phone:**

**Relation to Patient:**

### Insurance Information

**Billing Priority:** Primary

**Company:**

**Plan:**

**Policy/Group Number:**

**Insurance/Member Id Number:**

**Insurance Provider Phone:**

**Insured Name:**

**Insured Birthdate:**

**Patron's Relation to Insured:**

**Billing Priority:**

**Company:**

**Plan:**

**Policy/Group Number:**

**Insurance/Member Id Number:**

**Insurance Provider Phone:**

**Insured Name:**

**Insured Birthdate:**

**Patron's Relation to Insured:**

### Employer Information

**Employer:**

**How long with current employer:**

**Occupation:**

**Address 1:**

**State:**

**Zip:**

**Address 2:**

**City:**

### Dental Questionnaire (adult)

1. **Are you concerned about any teeth treated with root canal therapy?** ☐ Yes ☐ No

   If yes, please elaborate (i.e. upper, lower, right, left, how many years ago, what do you notice about it/them?):

2. **Are you concerned about previous teeth extraction sites (including wisdom teeth)?** ☐ Yes ☐ No

If yes, please elaborate (i.e. upper, lower, right, left, how many years ago, what do you notice about the area(s)?):

**3. Are you concerned about amalgam (mercury/silver) fillings?** ☐ Yes ☐ No

**4. Have you received orthodontic treatment?** ☐ Yes ☐ No

If yes, please elaborate (i.e. when, by whom, how well was treatment tolerated):

**5. Head / Face: please indicate any of the following you are now experiencing**

☐ Forehead headaches ☐ Temporal headaches ☐ Tension headaches ☐ Migraine-type headaches
☐ Sinus headaches ☐ Scalp tender to touch ☐ Back of head headaches
☐ Other (please explain) / Comments:

**6. Neck: please indicate any of the following you are now experiencing**

☐ Lack of mobility ☐ Tired/sore neck muscle ☐ Neck pain ☐ Stiffness
☐ Shoulder pain ☐ Back pain ☐ Arm/finger pain or numbness
☐ Other (please explain) / Comments:

**7. Jaw Pain: please indicate any of the following you are now experiencing**

☐ Jaw pain ☐ Jaw joint pain ☐ Jaw locks open/shut ☐ Grinding sound in jaw point(s)
☐ Pain in cheek muscles ☐ Clicking/popping in jaw ☐ Uncontrollable jaw movements
☐ Deviation of jaw to one side ☐ Other (please explain) / Comments:

**8. Ears: please indicate ay of the following you are now experiencing**

☐ Ear pain without infection ☐ Decreased hearing ☐ Clogged/stuffy feeling in ear(s)
☐ Rining/buzzing in ear(s) ☐ Dizziness ☐ Balance problems
☐ Other (please explain) / Comments:

**9. Eyes: please indicate any of the following you are now experiencing**

☐ Pain in/around eyes ☐ Bloodshot eyes ☐ Sensitivity to light ☐ Tearing of eyes
☐ Blurred vision ☐ Pressure behind eyes ☐ Dark circles under eyes
☐ Other (please explain) / Comments:

**10. Mouth: please indicate any of the following you are now experiencing**

☐ Abnormal opening ☐ Limited opening. ☐ Bad bite ☐ Missing Teeth
☐ Clenching/ grinding teeth ☐ Mouth discomfort ☐ Inability to bite ☐ Burning tongue
☐ Sour or foul taste in mouth ☐ Other (please explain) / Comments:

**11. Teeth: please indicate any of the following sensitivities you are now experiencing**

☐ Hot ☐ Cold ☐ Chewing/biting down ☐ Pressue
☐ Sweet ☐ Sour ☐ Food catches between teeth
☐ Other (please explain) / Comments:

**12. Gums: please indicate any of the following sensitivities you are now experiencing**

☐ Swollen or inflamed ☐ Tenderness ☐ Bleed when brushing
☐ Frequent sores ☐ Burning sensation ☐ Bleed when flossing
☐ Other (please explain) / Comments:

**13. Throat: please indicate any of the following you are now experiencing**

☐ Sore throat without infection ☐ Laryngitis ☐ Difficulty swallowing
☐ Frequent coughing or clearing ☐ Voice changes ☐ Feeling of foreign object in throat
☐ Other (please explain) / Comments:

**14. Nasal: please indicate any of the following you are now experiencing**

☐ Sinus pain ☐ Sinus problems ☐ Post-nasal drainage ☐ Allergies
☐ Other (please explain) / Comments:

**15. Sleep: please indicate any of the following you are now experiencing**

☐ Snoring ☐ Have been told I stop breathing ☐ Have been told I snore
☐ Sleep apnea ☐ Have awoken gasping for air ☐ Wear over the counter oral appliance
☐ Other (please explain) / Comments:

16. **What is/are your main concern(s)?**

## Health History Questionnaire

1. **Are you under a physicians care now?** ☐ Yes ☐ No
   If yes, please explain:

2. **Have you ever been hospitalized or had a major operation?** ☐ Yes ☐ No
   If yes, please explain:

3. **Have you ever had a serious head or neck injury?** ☐ Yes ☐ No
   If yes, please explain:

4. **Are you taking any medications, pills, or drugs?** ☐ Yes ☐ No
   If yes, please provide a separate list including brand name, product name, dosage, frequency, etc.

5. **Do you take, or have you taken, Phen-Fen or Redux?** ☐ Yes ☐ No

6. **Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?** ☐ Yes ☐ No

7. **Are you on a special diet?** ☐ Yes ☐ No
   If yes, please elaborate:

8. **Do you use tobacco?** ☐ Yes ☐ No

9. **Do you use controlled substances or drink alcohol?** ☐ Yes ☐ No
   If yes, please elaborate:

10. **Do you need to pre-medicate before dental procedures?** ☐ Yes ☐ No
    If yes, please explain:

11. **Are you...** ☐ Pregnant or trying to get pregnant ☐ Taking oral contraceptives ☐ Nursing

12. **Are you allergic to any of the following?** ☐ Yes ☐ No

☐ Acrylic
☐ Amoxicillin
☐ Aspirin
☐ Codeine
☐ Epinephrine
☐ Food _____
☐ Latex
☐ Local Anesthetics
☐ Metal _____
☐ Antibiotic _____
☐ Sulfa drugs
☐ Other (please explain) / Comments: _____

13. **Do you have, or have you had, any of the following?**

☐ AIDS or HIV Positive
☐ Alzheimers Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis or Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Autism
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise Easily
☐ Cancer
☐ Cell Disease
☐ Chemotherapy
☐ Chest Pains
☐ Congenital Heart Disorder
☐ Convulsions
☐ Colitis
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells / Dizziness
☐ Fibromyalgia
☐ Chronic Fatigue
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Glaucoma
☐ Hashimotos
☐ Hay Fever
☐ Heart Attack or Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart 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
☐ Lupus
☐ Lyme Disease
☐ Mental Disability
☐ Mitral Valve Prolapse
☐ Nervous System
☐ Nutritional De ciency
☐ Osteoporosis
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Skin Problems/ Eczema
☐ Spina Bida
☐ Stomach or Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease / STD
☐ Yellow Jaundice
☐ Whooping Cough/Mumps

14. **Have you ever had any serious illness not listed above?** ☐ Yes ☐ No

If yes, please elaborate:

15. **Is there any other medical information you feel the doctor should know about?** ☐ Yes ☐ No

If yes, please elaborate:

16. **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:** _____

## Other Information

**Referred By:** **Primary Physician:**

**How did you find us?:**

## Consent & Acknowledge of Receipts

**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. • Office Policies and Procedures • HIPAA Privacy Practices • Dental Materials Fact Sheet 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. https://weccles.com/new-dental-patients/**

1. **OFFICE POLICIES AND PROCEDURES: 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 Level plans, as we are in-network), and financial responsibility. A copy of our policies accompanies can be found on our website, viewed in our office, and available upon request. 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.**

☐ 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.

2. **HIPAA PRIVACY PRACTICES 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.**

☐ I have receipted a copy of the “HIPAA 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., 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.

3. **DENTAL MATERIALS FACT SHEET This fact sheet is provided by the California Dental Associate. This document does not reflect our dental care philosophy and is solely mandated for us to provide.**

☐ 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.

4. **I am confirming my acknowledgment of the above provided information.**

**Signature:** _____ **Date:** _____



dds initlals: _____