EPIC DENTAL Spa

WELCOME

TODAY'S DATE _____

one ABOUT YOU

☐ MALE
☐ FEMALE
☐ PREFER NOT TO SAY

_____
PATIENT NAME

_____
WHAT DO YOU PREFER TO BE CALLED?

__/__/____ _____
DATE OF BIRTH AGE

_____
MAILING ADDRESS (STREET, CITY, STATE & ZIP)

_____
PHONE NUMBER

_____
EMAIL ADDRESS

_____
EMPLOYER & ADDRESS

_____
OCCUPATION

☐ MINOR ☐ MARRIED ☐ SEPARATED
☐ SINGLE ☐ DIVORCED ☐ WIDOWED

_____
SPOUSE NAME

DO YOU HAVE CHILDREN? ☐ YES ☐ NO

_____
HOW MANY?

WHO REFERRED YOU TO EPIC DENTAL SPA?

PLEASE HAVE YOUR INSURANCE CARD READY TO GIVE TO THE FRONT DESK

two ACCOUNT INFO

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

_____
FULL NAME

_____ _____
RELATION TO PATIENT SS#

_____
BILLING ADDRESS (STREET, CITY, STATE & ZIP)

_____
DRIVERS LICENSE #

_____
PHONE NUMBER

PAYMENT METHOD ☐CASH ☐CHECK ☐CREDIT

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

_____
INITIALS

three EMERGENCY

_____
WHOM SHOULD WE CONTACT?

_____ _____
RELATION TO PATIENT PHONE #

_____
MEDICAL DOCTOR

_____
MEDICAL DOCTOR PHONE #

Please continue to the back

five DENTAL INFORMATION

REASON FOR TODAY'S VISIT ☐ EXAM ☐ EMERGENCY ☐ CONSULTATION

ARE YOU IN PAIN? ☐ YES ☐ NO HOW LONG? _____ _____ PREVIOUS DENTIST

PLEASE INDICATE ANY OF THE FOLLOWING PROBLEMS

☐ DISCOMFORT, CLICKING, POPPING IN JAW
☐ RED, SWOLLEN, OR BLEEDING GUMS
☐ SENSITIVE TOOTH, TEETH, OR GUMS
☐ BLISTERS/SORES IN OR AROUND THE MOUTH
☐ OTHER _____

☐ LOST/BROKEN FILLING
☐ TEETH GRINDING
☐ RINGING IN EARS
☐ BROKEN / CHIPPED TOOTH

☐ STAINED TEETH
☐ LOCKING JAW
☐ BAD BREATH

_____ / / _____ LAST DENTAL EXAM

_____ / / _____ LAST DENTAL X-RAYS

TIMES A DAY YOU BRUSH? _____ TYPE OF TOOTH BRUSH BRISTLES ☐ SOFT ☐ MEDIUM ☐ HARD

TIMES A WEEK YOU FLOSS? _____ HOW WOULD YOU RATE YOUR SMILE? WORST 1 2 3 4 5 6 7 8 9 10 BEST

six PATIENT MEDICAL HISTORY

WHAT MEDICATIONS ARE YOU TAKING? _____

HAVE YOU EVER TAKEN: BISPHOSPHONATES? (EX. AREDIA/FOSAMAX) ☐ YES ☐ NO PHEN-FEN/REDUX ☐ YES ☐ NO

DO YOU HAVE OR HAVE ANY OF THE FOLLOWING DISEASES, MEDICAL CONDITIONS OR PROCEDURES?

☐ HEART ATTACK / STROKE
☐ HEART SURGERY / PACEMAKER
☐ HEART MURMUR
☐ RHEUMATIC FEVER
☐ MITRAL VALUE PROLAPSE
☐ ARTIFICIAL VALVES
☐ HEART DISEASE
☐ CONGENITAL HEART DEFECT
☐ CHEST PAINS
☐ SCARLET FEVER
☐ NERVOUSNESS
☐

☐ THYROID PROBLEMS
☐ KIDNEY PROBLEMS
☐ LIVER PROBLEMS
☐ RESPIRATORY PROBLEMS
☐ SINUS PROBLEMS
☐ STOMACH PROBLEMS / ULCERS
☐ PSYCHIATRIC PROBLEMS
☐ VENEREAL DISEASE
☐ ALCOHOL / DRUG ABUSE
☐ TUBERCULOSIS TB
☐ JAW PROBLEMS - TMJ/TMD

☐ CANCER / TUMORS
☐ SHINGLES
☐ HEPATITIS
☐ HIV+ / AIDS / ARC
☐ ARTHRITIS / RHEAUMATISM
☐ ARTIFICIAL BONES/JOINS
☐ EMPHYSEMA
☐ FAINTING / SEIZURES / EPILEPSY
☐ SEVERE / FREQUENT HEADACHES
☐ FREQUENT NECK PAIN
☐ BACK PROBLEMS

☐ COSMETIC SURGERY
☐ XRAY OR COBALT TREATMENT
☐ CHEMOTHERAPY
☐ ASTHMA
☐ DIFFICULTY BREATHING
☐ DIABETES / HYPOGLYCEMIA
☐ LEUKEMIA
☐ ANEMIA
☐ HIGH/LOW BLOOD PRESSURE
☐ BLEEDING PROBLEMS
☐ GLAUCOMA

SURGERIES OR MEDICAL CONDITIONS YOU HAVE OR EVER HAD _____

ARE YOU ALLERGIC TO ANY OF THESE? ☐ LATEX ☐ PENICILLIN / AMOXICILLIN ☐ TETRACYCLINE ☐ ASPIRIN ☐ DENTAL ANESTHETICS ☐ FOODS _____ ☐ OTHER _____

DO YOU USE TOBACCO? ☐ YES ☐ NO

PLEASE RATE YOUR GENERAL HEALTH WORST 1 2 3 4 5 6 7 8 9 10 BEST DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

for women

ARE YOU TAKING BIRTH CONTROL? ☐ YES ☐ NO ARE YOU PREGNANT? ☐ YES ☐ NO

HAVE MANY CHILDREN HAVE YOU HAD? _____ HOW MANY MONTHS? _____

- WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST DENTAL HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.
- OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE BUSINESS MANAGER. IF ACCOUNT IS NOT PAID WITHIN 90 DAYS OF THE DATE OF SERVICE AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR LEGAL FEES, COLLECTION AGENCY FEES, INTEREST CHARGES AND OTHER EXPENSES OCCURRED IN COLLECTING YOUR ACCOUNT.
- I AUTHORIZE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT, I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.
- I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE INFORMATION I HAVE PROVIDED.
- I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE SUMMARY OF PRIVACY NOTICE

_____

SIGNATURE ☐ ADULT PATIENT ☐ PARENT OR GUARDIAN ☐ SPOUSE

EPIC DENTAL Spa