

# PATIENT INFORMATION

## PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
IF A CHILD, RESPONSIBLE PARTY'S NAME \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SOCIAL SECURITY NUMBER OF PATIENT \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
PATIENT EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
\_\_\_\_\_  
DRIVER'S LICENSE NO. \_\_\_\_\_

## ACCOUNT INFORMATION PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
BUSINESS PHONE NO. \_\_\_\_\_

## INSURANCE INFORMATION PRIMARY CARRIER

INSURANCE COMPANY \_\_\_\_\_  
GROUP NO. \_\_\_\_\_  
EMPLOYEE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
UNION OR LOCAL NO. \_\_\_\_\_  
EMPLOYEE SOC. SEC. NO. \_\_\_\_\_

## SECONDARY CARRIER

INSURANCE COMPANY \_\_\_\_\_  
GROUP NO. \_\_\_\_\_  
EMPLOYEE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
UNION OR LOCAL NO. \_\_\_\_\_  
EMPLOYEE SOC. SEC. NO. \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? \_\_\_\_\_ PHONE \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

# DENTAL HISTORY

<b>Patient Name</b>	<b>Medical Alert</b>
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What is the reason for your visit today? \_\_\_\_\_

**Date of Last Dental Visit** \_\_\_\_\_ **Last Dental Cleaning** \_\_\_\_\_ **Last Full Mouth X-Rays** \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

**How often do you have dental examinations?** \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

**Do you have any dental problems now?** Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

**Do your gums bleed or hurt?** Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

**Have you ever had:**

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

**Are you satisfied with teeth's appearance?** Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No

If yes, please describe \_\_\_\_\_

**Is there anything else about having dental treatment that you would like us to know?** ..... Yes No

If yes, please describe \_\_\_\_\_



**Eaglesoft Medical History 9/2017**

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Date Created: \_\_\_\_\_

**Physician Information**

Primary Care Provider/Physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> 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 AnestheticsOther? ☐

If yes \_\_\_\_\_

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Corticosteroid Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No	CPAP	<input type="radio"/> Yes <input type="radio"/> No	Snoring	<input type="radio"/> Yes <input type="radio"/> No		

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

If yes \_\_\_\_\_

**Comments:**

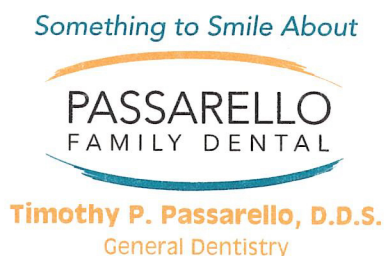
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: \_\_\_\_\_

X

Date: \_\_\_\_\_

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## FINANCIAL POLICY

Good dental care and oral health that results from this care are sound investments in a person's overall health and wellbeing. To achieve this state of health, our office practices the latest in preventive and restorative techniques. We urge our patients to take part in maintaining their dental health by practicing a program of thorough home care and regular preventive maintenance appointments.

1. As a service to our patients with dental insurance we accept assignment of benefits. All deductibles and co-payments must be paid at the time of service. After 60 days, if payment has not been received from the insurance company, any remaining balance will immediately become the patient's responsibility. Please keep in mind that insurance companies routinely indicate that coverage verification does not guarantee payment. Due to the complex nature of dental insurance, we cannot be responsible for finding out the details of each patient's particular insurance situation. Ultimately, the responsibility for all incurred charges lies with the patient.
2. For all insurance plans in which we do not participate, payment must be paid at time of service; reimbursement will be made by your insurance company directly to you.
3. Patients without dental insurance, payment for all services is due at the time of treatment. For your convenience, we accept payment by cash, check, or major credit card (Visa, MasterCard, American Express, or Discover).
4. Payment plans are available through a third-party source (Care Credit or Capitol One). Please ask if this may be appropriate for you.
5. We require that all fees for emergency services be paid at the time of service.
6. There will be a \$25.00 charge for returned checks.
7. There will be a late payment fee of \$30.00 if payment is not received by the due date.
8. A finance charge of 1.5% per month on the unpaid balance will be added monthly.
9. Accounts sent to collections will be liable for all costs. The cost will not exceed a 33% collection fee. Patient is also responsible for any legal fees.
10. We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, our policy is that any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 48 hours in advance of their appointment will be charged a fee of \$45 per occurrence. For Monday appointments, cancellations must be made on the preceding Wednesday.

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Patient Name

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Date

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Patient/Parent/Guardian Signature