

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First MI (Preferred Name)*

Parent or Guardian's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Social Security: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Would you like to have upcoming appointment reminders by email? No Yes  
email: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Apartment #*

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**HEALTH HISTORY**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Stomach Problems             | <input type="checkbox"/> Hydrocodone Allergy                        |
| <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Hepatitis A, B, C    | <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Tetracycline Allergy                       |
| <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Anemia               | <input type="checkbox"/> GERD                         | <input type="checkbox"/> Penicillin Allergy                         |
| <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Low Thyroid                  | <input type="checkbox"/> Sulfa drug Allergy                         |
| <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Thyroid removal              | <input type="checkbox"/> Erythromycin Allergy                       |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rheumatism/Arthritis | <input type="checkbox"/> Replacement therapy          | <input type="checkbox"/> Cephalosporin Allergy                      |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Hyperthyroid                 | <input type="checkbox"/> Anesthetic Allergy                         |
| _____   | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Nervous Disorders            |   |
| <input type="checkbox"/> Heart Trouble          | <input type="checkbox"/> COPD                 | <input type="checkbox"/> Mental Disorders             | <b>OTHER ALLERGIES</b>  |
| <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Depression/Anxiety           | <input type="checkbox"/> Latex Allergy                              |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Fainting             | <input type="checkbox"/> <i>Pregnancy - currently</i> | <input type="checkbox"/> Acrylic Allergy                            |
| <input type="checkbox"/> Head Injuries          | <input type="checkbox"/> Benign Growths       | Due date: _____                                       | <input type="checkbox"/> Metal Allergy                              |
| <input type="checkbox"/> Stroke _____           | <input type="checkbox"/> Cancer _____         | <input type="checkbox"/> Bisphosphonate meds          | <input type="checkbox"/> Adhesive Allergy                           |
| <input type="checkbox"/> Seizures/Epilepsy      | <input type="checkbox"/> Radiation Treatment  |   | <input type="checkbox"/> Adverse Reaction to any other drugs/other: |
| <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Chemotherapy         | <b>DRUG ALLERGIES</b>                                 | _____   |
| <input type="checkbox"/> Diabetes type I or II  | <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Ibuprofen Allergy            | <b>OTHER Health Problems not listed:</b>                            |
| <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Immune Deficiencies  | <input type="checkbox"/> Aspirin Allergy              | _____   |
| <input type="checkbox"/> Organ Transplant       | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tylenol Allergy              | _____   |
| <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> Codeine Allergy              | _____   |

- What is your weight \_\_\_\_\_ lb? Height? \_\_\_\_\_
- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  
 Yes  No  
If yes, please explain: \_\_\_\_\_
- Physician name and number \_\_\_\_\_

- Please list all Medications and vitamins and supplements you are currently taking: (or provide list to photocopy)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

Signature of doctor reviewing medical history \_\_\_\_\_ Date: \_\_\_\_\_

**SPOUSE OR RESPONSIBLE PARTY INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First MI (Preferred Name)*  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
Social Security: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street Apartment #*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

The following is for:  the patient  the person responsible for payment  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street Apartment #*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
*Last First MI*  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
*Street Apartment #*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Employers Address: \_\_\_\_\_  
*Street Apartment #*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

**Secondary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
*Last First MI*  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
*Street Apartment #*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Employers Address: \_\_\_\_\_  
*Street Apartment #*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

**DENTAL HISTORY**

Primary Reason for appointment:  Exam  Emergency  Esthetic Consultation & Smile Makeover

Do you have a specific dental problem you would like addressed? \_\_\_\_\_

Do you have dental examinations on a regular basis?  Yes  No

Name of your previous Dentist? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

Are your teeth Sensitive to:  Cold  Hot  Sweet  Biting  Touch

Do you think you have active decay?  Yes  No

Do you think you have gum disease?  Yes  No

Do your gums bleed?  Yes  No

Have you been taught to control gum disease?  Yes  No

How often do you brush?  Twice Daily or more  Once Daily  Weekly  Not on a regular basis  Do NOT brush

How often do you floss?  Twice Daily or more  Once Daily  Weekly  Not on a regular basis  Do NOT floss

Have you ever had  Scaling and Root Planing?  Gum Surgery?  TMJ therapy/surgery?  Braces?

Do you clench or grind your teeth?  Yes  No

Do you wear a grinding guard/night guard?  Yes  No

Do you have clicking or popping in the jaw joint?  Yes  No

Do you have discomfort in the jaw joint?  Yes  No

Do you have any sores, ulcers or growths in your mouth? \_\_\_\_\_

Do you smoke or chew tobacco products?  Yes  No If yes, how much/for how long \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No If yes, how often?  Never  Seldom  More than 2/day

Do you use recreational drugs?  Yes  No

Have you're past dental experiences always been positive?  Yes  No Please explain: \_\_\_\_\_

Do you have any fear of dental treatment?  Yes  No

Are you pleased with the appearance of your teeth?  Yes  No

Would you like your teeth whitened?  Yes  No

Describe any other changes you would like in the appearance of your teeth: \_\_\_\_\_

Please sign that the above information is true to the best of your knowledge

Signature of patient, parent or guardian \_\_\_\_\_ Today's Date: \_\_\_\_\_

Print Patient Name Last First Mi Date of Birth: \_\_\_\_\_

**REFERRAL INFORMATION**

Whom may we thank for referring you to our practice?

Another patient \_\_\_\_\_

Friend or Relative \_\_\_\_\_

Insurance  Web Page  Yellow Pages  Newspaper  School  Work  Other

ALTHEA EGGLESTON D.D.S. P.A  
1209 West 5<sup>th</sup> Street St.#100-B  
Austin, TX 78703

## INSURANCE

**IT IS THE PATIENT'S RESPONSIBILITY TO PAY ANY PORTION OF THE BILL THAT IS NOT COVERED BY HIS/HER DENTAL INSURANCE WITHIN 30 DAYS.**

I have read the above statement and I understand that any unpaid balance that remains after my insurance has paid is my responsibility.

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Patient Signature

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Date

## ACKNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT

I have been made aware of the HIPPA Privacy Practices Notice for Dr. Althea Eggleston, DDS, PA on 1209 West 5<sup>th</sup> Street Suite 100-B., (which is posted in the waiting room, and I was given the opportunity to read a copy) which went into effect April 14, 2003.

X \_\_\_\_\_  
Print Name of Patient

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Individual OR Representative/Relationship to Individual Date

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## FINANCIAL RESPONSIBILITY

I authorize release of any Dental information necessary to process insurance claims. I also request payment of benefits to be made to Dr. Althea Eggleston, DDS, PA. Insurance Claims: While we do our best to determine your out of pocket expenses at the time of service, we cannot be certain until your insurer pays your claim. At that time, we will bill you for any unpaid balance or refund any overpayments.

X \_\_\_ A \$50.00 fee will be applied to your account for any missed appointments or cancellations with less than 24 hour notice.

X \_\_\_ We process your payment by personal check as an electronic debit. For any reason your check is not authorized through Retriever, another form of payment is due.

X \_\_\_ An interest rate charge of 10% plus collection fees will be assessed for balances not paid within 30 days.

Patient Initial \_\_\_\_\_

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take radiographs, dental impressions, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_