EON CLINICS
Dental Implants for Life

Patient Information

Full Legal Name (First, Middle, Last) | Date of Birth (/ /) | Age | Gender

Residential Address

City | State | Zip Code

Home Phone # | Cell Phone # | Work Phone #

Email Address | Driver's License # | Social Security #

May we contact you via email? (Circle one) Yes / No

Where and when are the best times to reach you?

Employer Information

Employer | Occupation

Employer's Address

City | State | Zip Code

Dental Habits

How often do you brush your teeth? ☐ Weekly ☐ Once a day ☐ 2+ times a day

How often do you floss your teeth? ☐ Rarely/never ☐ Daily ☐ Other

How often do you visit a dentist? ☐ 1+ times a year ☐ Every few years ☐ Rarely/never

Do you have a family dentist? Yes / No

Dentist's Name (if applicable) | Last Visit

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Dental Condition

Issue	Yes	No	Details
Are you unhappy with the appearance of your teeth?			
Do your teeth/gums hurt?			
Do your teeth limit the foods you can eat?			
Do your teeth limit your ability to speak clearly?			
Do your teeth affect your confidence?			
Do you grind your teeth?			
Do your gums bleed or hurt?			
Have you lost teeth?			
Are any of your teeth loose?			
Have you had teeth removed/extracted?			
Have you had missing teeth replaced?			
Have you ever had gum surgery?			
Are your teeth sensitive to hot, cold, pressure, or sweets?			
Do you have a partial denture?			
Do you have a full denture?			

How is your current dental condition affecting you? _____

How would your life change with dental implants? _____

Consent for 3-D CT Scan

During your initial consultation, we will take a complimentary diagnostic 3-D CT scan for our internal use only. The scan gives us the most accurate image of teeth and bone. We will discuss all available treatment options, along with pricing and financing, so you have all the information you need to make an informed decision about the best treatment option for you. If you wish to obtain a copy of the CT scan, a $500 fee will apply.

I understand that CT scan imaging is for internal use only. I authorize consent to the performance of this imaging procedure.

_____ _____

Patient Signature Date