

Patient Information

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

Home Address

City **State** **Zip Code**

Home (or other) Phone #

Cell Phone #

Best times to reach you:

Driver's License #

Social Security #

Email Address

OK to email you?

Employer Information

I am: **Employed (see below)** **Disabled** **Retired**

Employer **Occupation**

Employer Address **Employer Phone #**

City **State** **Zip Code**

How did you hear about EON Clinics?

TV **Radio** **Newspaper** **Internet** **Family/Friend** **Other:** _____

Dental Habits

How often do you brush your teeth?	<input type="checkbox"/> Weekly	<input type="checkbox"/> Once/day	<input type="checkbox"/> 2+ times/day
How often do you floss your teeth?	<input type="checkbox"/> Rarely/never	<input type="checkbox"/> Daily	<input type="checkbox"/> Other
Do you grind your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
How often do you visit a dentist?	<input type="checkbox"/> 1+ times/year	<input type="checkbox"/> Every few years	<input type="checkbox"/> Rarely/never

Dentist's Name (If applicable)

Dentist's Phone #

Last Visit

Name: _____ Date: _____

Dental Condition

Issue	No	Yes	Details
Are you Unhappy with the appearance of your teeth?			
Do your teeth/gums hurt?			
Do your teeth limit the foods you can eat?			
Have you been told you have bad breath?			
Do your teeth limit your ability to speak clearly?			
Do your teeth affect your confidence?			
Are your teeth sensitive to heat, cold, pressure, sweets?			
Do your gums bleed or hurt?			
Have you ever had gum surgery?			
Are any of your teeth loose?			
Have you lost teeth?			
Have you had teeth removed/extracted?			
Have you had missing teeth replaced?			
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 complementary 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



Name: _____ Date: _____

To our patients: Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health issues you have or medications you are taking impact the care Eon Clinics provides. Thank you for assisting us in providing optimum care by answering the following questions. All answers are confidential.

Describe your overall health: Excellent Good Fair Poor

Height: _____ Weight: _____ Date of last physical exam: _____

In the past year, have you had any changes in your general health? No Yes: _____

Are you under the care of a physician for any condition? No Yes: _____

In the last five years, have you had a serious illness or been hospitalized: No Yes: _____

Have you been advised to premedicate prior to dental treatment? No Yes: _____

ANY possibility you may be pregnant? No Yes Are you nursing? No Yes Are you taking contraceptives? No Yes

Medical History

Heart Problems	No	Yes	If yes, explain:
Chest pain/Angina			
Heart Attack			
Heart Surgery			
Shortness of Breath			
Blood Pressure Problems			
Heart Murmur			
Heart Valve Problem			
Artificial Heart Valve			
Taking Heart Medication			
Rheumatic Fever			
Pacemaker			
Irregular Heart Beat			
Blood Problems	No	Yes	
Easy Bruising			
Nosebleeds			
Abnormal Bleeding			
Blood Disease			
Blood Transfusion			
Allergies	No	Yes	
Hay Fever/Allergies			
Sinus Problems			
Medication Allergies			
Food Allergies			
Intestinal Problems	No	Yes	
Ulcers			
Bariatric Surgery			
Significant Weight Loss/Gain			
Special Diet			
Constipation or Diarrhea			
Kidney Problems			
Bladder Problems			
Breathing/Lung Problems	No	Yes	
Asthma			
Sleep Apnea			
Need Extra Pillows for Sleep			
Snoring			
Use CPAP			

COPD			If yes, explain:
Emphysema			
Tuberculosis			
Cancers or Tumors	No	Yes	
Cancer			
Radiation Treatment			
Chemotherapy Treatment			
Bone or Joint Problems	No	Yes	
Arthritis			
Joint Replacement			
Osteoporosis			
Back or Neck Pain			
Back or Neck Surgery			
Other	No	Yes	
Fainting Spells, Seizures, Epilepsy			
Hepatitis B or C			
Jaundice/Liver Problems			
Thyroid Problems			
Cold Sores, Herpes or STDs			
HIV+ or AIDS			
Glaucoma			
Contact Lenses			
Pain Management/Treatment			
Alcohol Use			
Prescription Drug Abuse			
Recreational Drug Abuse			
Marijuana Use			
Tobacco or E-Cig Use			
Chewing Tobacco Use			
	No	Yes	
Diabetes			
Stroke			
Any other Illnesses or Conditions?			
If yes, explain:			



Name: _____ Date: _____

Do you take, or have you ever taken the following Medications?

- Anticoagulants/blood thinners
- Blood pressure medication
- Antidepressants/Anti-anxiety medication
- Tranquilizers
- Cortisone/steroids
- Diet pills (prescription)
- Herbal supplements
- Non-prescription drugs
- Bone density medication or bisphosphonates
 - Fosamax (alendronate)
 - Actonel (risedronate)
 - Boniva (ibandronate)
 - Skelid (tiludronate)
 - Didronel (etidronate)
 - Aredia (pamidronate)
 - Zometa (zoledronic acid)

List any other Medications: _____

Are you allergic or have you reacted adversely to the following? Check if "yes."

- Local anesthetics "Novacaine"
- Penicillin or other antibiotics
- Sulfa Drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin, acetaminophen, ibuprofen
- Codeine, Demerol, other narcotics
- Metals, Latex or Iodine
- Other(Please specify) _____

Primary Care Physician: _____ Phone: _____

Other Medical Provider: _____ Phone: _____

Pharmacy Name and Location: _____ Phone: _____

I hereby certify that I have read and understand the above. I acknowledge that my questions, if any, about the above health history questionnaire have been answered to my satisfaction. I will not hold my surgeon or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date _____ Reviewed _____

UPDATE _____ CHANGES _____
UPDATE _____ CHANGES _____
UPDATE _____ CHANGES _____

Doctor's Notes: _____

HIPAA CONSENT

Consent for Release of Information for Treatment, Payment, and Health Care Operations

The Health Insurance Portability and Accountability Act (HIPAA) requires that EON CLINICS make available to you a description of how medical information about you may be used or disclosed and how you can get access to this information. This is called the Notice of Privacy Practices and copies are available on the receptionist's desk and waiting room. I acknowledge that a copy of this notice has been made available to me. **_____ initial**

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

I, **_____**, authorize EON CLINICS to use or disclose my health information to carry out my treatment, obtain payment, and for health care operations.

In addition to the above, I authorize the following:

1. My Medical condition and information may be discussed with the following persons:

Name _____ Relationship _____

Name _____ Relationship _____

- | | | | |
|---|-----|----|-----|
| 2. Leave a message on my phone voicemail or answering machine? | Yes | No | |
| 3. Leave a message with a person who answers my home phone? | Yes | No | |
| 4. Receive mail at home from Eon Clinics other than billing statements. | Yes | No | N/A |
| 5. Contact me at work and tell them who is calling if asked? | Yes | No | N/A |
| 6. Leave a message on my work phone voicemail or answering machine? | Yes | No | N/A |

Signature of patient (or patient's representative)

Date

Printed name of patient (or patient's representative)

Representative's relationship to patient