EON CLINICS
Dental Implant Solutions for Life

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 #**

__________________________ __________________________

Driver's License # **Social Security #**

Best times to reach you:

____

Email Address: ____ **OK to email you?____Yes____No**

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?	___ Weekly	___ Once/day	___ 2+ times/day
How often do you floss your teeth?	___ Rarely/never	___ Daily	___ Other
Do you grind your teeth?	___ Yes	___ No	___ Don't know
How often do you visit a dentist?	___ 1+ times/year	___ Every few years	___ Rarely/never

__________________________ __________________________ __________________________

Dentist's Name (If applicable) **Dentist's Phone #** **Last Visit**

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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
  - o Fosamax (alendronate)
  - o Actonel (risedronate)
  - o Boniva (ibandronate)
  - o Skelid (tiludronate)
  - o Didronel (etidronate)
  - o Aredia (pamidronate)
  - o 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: ____

____

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____

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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