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PATIENT INFORMATION

Patient Name: _____ Today's Date: ____/____/____

LAST FIRST MI

MALE FEMALE MARRIED SINGLE OTHER _____

SOCIAL SECURITY# _____ BIRTH DATE: _____

PHONE (HOME) _____ (WORK) _____ EXT: _____ OTHER _____

ADDRESS _____

STREET APT #

CITY STATE ZIP CODE

EMAIL ADDRESS: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ PHONE _____

MEDICAL HISTORY

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | OTHER: |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Smoke: Yes/No | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Dis/Jaundice | Packs/day: _____ | |
| | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke | |

ADDITIONAL HEALTH INFORMATION:

Are you taking any prescribed or over the counter medications? Yes No

If yes, please list: _____

Have you been diagnosed with acid reflux disease or do you experience frequent heartburn? Yes No

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you under the care of a physician? Yes No

If yes, please explain: _____

Name of primary care physician: _____ Phone : _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

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 status, I will inform the doctors at the next appointment.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

ACCOUNT INFORMATION
PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____

SS #: _____

RELATION: _____

BILLING ADDRESS: _____

CITY STATE ZIP

EMPLOYER NAME: _____ WORK PHONE #: _____

HOME PHONE #: _____ OTHER PHONE #: _____

REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? ANOTHER PATIENT DENTAL OFFICE
 YELLOW PAGES NEWS PAPER WORK INTERNET/WEB SITE OTHER _____

NAME OF PERSON OR OFFICE REFERRING YOU TO OUR PRACTICE: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

CO. NAME: _____

ADDRESS: _____

PHONE# _____

CITY	STATE	ZIP
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INSURED'S ID# _____

INSURED'S NAME: _____

RELATION: _____ DATE OF BIRTH: ____/____/____

GROUP # _____

SECONDARY DENTAL INSURANCE

CO. NAME: _____

ADDRESS: _____

PHONE# _____

CITY	STATE	ZIP
------	-------	-----

INSURED'S ID# _____

INSURED'S NAME: _____

RELATION: _____ DATE OF BIRTH: ____/____/____

GROUP # _____

CONSENT FOR SERVICES

I hereby authorize the doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs.

I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk including numbness and adverse medical reactions.

I authorize the provider to release any information required to process insurance claims. I also assign all insurance benefits to the Doctor. I understand that my dental insurance is a contract between my insurance carrier and me; not between the insurance carrier and the Doctor. I understand and acknowledge that I am financially responsible for services provided regardless of insurance coverage. These fees are due and payable at the time of services rendered.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

relationship to patient