Time 1:20 PM

THE LODI DENTIST

Date 9/23/2016

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No
Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No	Angina	Yes No
Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No
Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No
Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No	Artificial Joint	Yes No
Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No
Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No
Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No	Blood Transfusion	Yes No
Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Breathing Problems	Yes No
Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No	Bruise Easily	Yes No
Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No	Glaucoma	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No
Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No
Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No
Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No
Parathyroid Disease	Yes No	Ulcers	Yes No	Convulsions	Yes No	Heart Trouble/Disease	Yes No
Psychiatric Care	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No		

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Signature

Signature of Doctor Yes No

DENTAL HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches,ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Food catching between teeth
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

Please share the following dates:

Your last cleaning _____/_____
Your last oral cancer screening _____/_____
Your last complete x-rays _____/_____

Name of Previous Dentist:

_____
City: _____ State: _____
Phone number: _____

What is the most important thing to you about your future smile and dental health?

_____
_____
_____

_____
_____

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

Do you smoke or use chewing tobacco? _____
How much? For how long?

_____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns thet don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your **current** dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____
_____
_____

What is the most important thing to you about your dental visit today?

_____
_____
_____

_____
_____

THE LODI DENTIST

David Neal, DDS, & Mary Hoff, DDS

1104 S. Fairmont Ave • Lodi, CA 95240 • (209) 369-3657

FINANCIAL AGREEMENT FOR THE LODI DENTIST

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's overall health and quality of life. Financial considerations should not be an obstacle to obtaining this important care. To assist you in choosing the method of payment that is best for your situation, we have several financing options available.

Unless financial arrangements are made in advance, fees are due and payable at the time treatment is rendered. We accept cash, personal checks, or credit cards (MC, Visa, American Express, Discover and Carecredit).

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. Payment for your estimated portion is due and payable at time of service. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. We ask that you pay this balance upon receipt of invoice.

I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that i am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full will become my responsibility to pay.

Patient (or Responsible Party) Signature: _____ Date: _____

RESERVATION AGREEMENT

As our patient, and to ensure we deliver exceptional dental care, we want to assure you that we are 100% committed to providing timely and quality service to all our patients'. We believe an equally important aspect of delivering exceptional dental care is our patients commitment to our practice as well. Therefore, we request you honor your scheduled appointment as a "reservation" as we reserve that time specifically and only for you.
Should you have to change your reservation for any reason, we request you give our practice a minimum of 48 hours' (2 business days) notice.

Missed appointments increase the cost of healthcare for everyone; therefore if a reserved appointment is missed or changed without 48 hours' notice you may be required to pay a $25.00 reservation fee in order to reserve your next appointment. The reservation fee will then be applied to any treatment rendered, or forfeited if your reserved appointment is missed or canceled without the required 48 hours' notice. We appreciate your understanding in this matter.

Patient (or Responsible Party) Signature: _____ Date: _____