

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION		
Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____		
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.		
DENTAL HISTORY & SYMPTOMS		
What is the reason for your visit today?		
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?		
When was your last dental exam? / / What was done at that appointment?		
When was the last time you had dental x-rays taken?		
Please mark an "X" in the box ONLY if this applies to you.		
Is it hard to open your mouth? <input type="checkbox"/> Does it hurt to chew, bite or swallow? <input type="checkbox"/> Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/> Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/> Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/> Do you clench or grind your teeth? <input type="checkbox"/> Does your jaw click, pop or hurt? <input type="checkbox"/> Do you have earaches or neck pains? <input type="checkbox"/> Does dental treatment make you nervous? <input type="checkbox"/> Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/> <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep	Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> If yes, please describe what happened and when it happened: _____ _____ Have you ever had problems with dental treatment in the past? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/> If yes, please describe what happened: _____ _____ Are you unhappy with your smile? <input type="checkbox"/> If yes, why? Please mark all that apply: <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth <input type="checkbox"/> Other. Please describe: _____	
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES		
Please use an "X" to mark your answers to the following questions. Yes No ?		
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
If yes, what medication are you taking? _____		
Are you taking any medication to treat osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).		
If yes, what medication are you taking? _____		
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).		
If yes, what medication are you taking? _____ How many years have you been taking it? _____		
Are you taking hormonal replacements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Do you use vaping products ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
How many alcoholic beverages do you have per week? _____		
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally		
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____		
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
If yes, please list them here and include information about how much and how often you use each one. _____		
WOMEN ONLY: Are you:		
Taking birth control pills ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Pregnant? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Nursing? If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes No ?	Yes No ?
Aspirin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapson, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other
Codeine or other narcotics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience.
Iodine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
Latex (rubber)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Local anesthetics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Metals	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /	What is your normal blood pressure (systolic, diastolic)?
Doctor's Name: _____	Phone: _____

Please use an "X" to mark your answers to the following questions.

Are you in good physical health?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you currently being seen or treated by a physician?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answered yes to any of the above, please explain: _____	

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

Heart (Cardiac) Health	Yes No ?	Cancer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No ?	Digestive Health	Yes No ?
Pacemaker/implanted defibrillator	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type: _____		Gastrointestinal disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Artificial (prosthetic) heart valve	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of diagnosis: _____		G.E. reflux/persistent heartburn (GERD).....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chemotherapy: _____		Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Radiation treatment: _____		Eye (Vision) Health	
Unrepaired, cyanotic CHD	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Glaucoma.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood (Circulatory) Health		Other	
Repaired CHD with residual defects	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____		Diabetes (type I or II)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	High or low blood pressure.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Brain (Neurological)/Mental Health		Type of infection: _____	
Heart murmur/rhythm disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anxiety	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Immune deficiency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Stroke	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Breathing (Respiratory) Health		Mental health disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma (COPD)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Post-traumatic stress disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Emphysema.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Traumatic brain injury or concussion.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted infection (STI).....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sinus trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune Disease		Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
		Lupus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes No ?	Yes No ?	Yes No ?
had pain or tightness in the chest?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
been exposed to anyone with tuberculosis?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
had a rapid or irregular heart beat?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			experienced vomiting, diarrhea, chills, night sweats or bleeding?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			had migraines or severe headaches?

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____

PATIENT INFORMATION

Date _____ Patients Full Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birthday _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

How did you find us? Referral _____ Yellow pages Internet Newspaper

Person to contact in case of Emergency _____ Phone # _____

Nearest relative not living with you _____ Phone # _____

ACCOUNT INFO PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____ Home# _____

Work # _____ Mobile # _____ Birthdate _____

Billing Address _____ City _____ State _____ Zip _____

Email _____ Employer _____ Employer Address _____

_____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Provider Name _____ Provider Address _____

City _____ State _____ Zip _____ Group # _____

Insured's Name _____ Relation _____ Insured's Birth Date _____

Insured's SSN # _____ Insured's Employer _____ Insured's Phone # _____

SECONDARY INSURANCE

Provider Name _____ Provider Address _____

City _____ State _____ Zip _____ Group # _____

Insured's Name _____ Relation _____ Insured's Birth Date _____

Insured's SSN # _____ Insured's Employer _____ Insured's Phone # _____

We require 3 signatures please...

**Practice Acknowledgments
Katrina Eglian, D.M.D.**

Dental Materials Fact Sheet

I, _____, received and read the Dental Materials Fact Sheet Summary from Dr. Eglian. I am aware that a full disclosure is available at the front desk.

X _____ X _____
Signature Date

Financial Guideline

I fully understand the Financial Guidelines for the office of Katrina Eglian, D.M.D.
I acknowledge that I am responsible for the payment of services regardless of insurance decision.
I understand that payments are due at the time of services, unless otherwise arranged.

X _____ X _____
Signature Date

Acknowledge of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices. You may refuse to sign this acknowledgment.

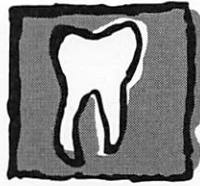
X _____ X _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other

Katrina Eglian, D.M.D.



Family and Cosmetic Dentistry

20921 Walnut Street
Red Bluff, CA 96080
Office (530) 527-7951
Fax (530) 527-7955

NO SHOW POLICY

We would like to take this opportunity to inform you of our NO SHOW POLICY.

An appointment is considered to be a "No-show" if the patient does not come to the scheduled appointment and when the appointment is canceled or rescheduled within two hours of the scheduled appointment.

Our No Show Policy is as follows:

When you schedule an appointment we look forward to being a part of your dental journey, and when you miss an appointment we miss you. We understand that things come up, but it is our mission to make sure your dental needs are met. After a missed appointment we will make every good faith effort to contact you. We may call you directly, leave a phone message, and/or send a letter asking you to contact us.

Please note: If a patient does not come to 3 scheduled visits in a 12 month period, or if a patient has excessive rescheduling or canceling of appointments, the patient may be discharged from our office.

When you sign this paper, you certify that you have read and understand the above information regarding our No Show, Cancellation, and Reschedule Policy, and understand that if you are unable to attend a scheduled appointment or bring your child to a scheduled appointment, it is your responsibility to contact us 24 hours in advance.

NAME OF PATIENT

PATIENTS DATE OF BIRTH

SIGNATURE OF PATIENT / RESPONSIBLE PARTY

DATE

Katrina Eglan, D.M.D.

20921 Walnut Street
Red Bluff, CA 96080
530-527-7951

In compliance with the HIPAA regulations and law, we are not able to speak w/ anyone other than you the patient regarding any medical information. If you have someone that you authorize us to leave information with or speak with regarding your medical care please list them below. Thank you.

1. _____

2. _____

3. _____

4. _____

5. _____

Patient Signature

Date