Gregory R. Eissmann, D.D.S.
Roland L. Postlewait, D.D.S.
Patrick Myatt, D.D.S.

Patient Information

Patient Name: Last, _____ First, _____ Preferred _____ Gender: ☐ Male ☐ Female

Social Security #: _____ Birth Date: _____ ☐ Married ☐ Single ☐ Child

Phone (Home): _____ (Work): _____ (Cell): _____

Email address: _____

Physical Address: Street _____

City _____ State _____ Zip Code _____

Billing Address: Street _____

City _____ State _____ Zip Code _____

In the event of an emergency, whom should we contact? Name: _____ Phone: _____

Employment Information

Employer Name: _____ Occupation: _____

Insurance Information

Dental Coverage ☐ Yes ☐ No

Insurance Plan Name: _____

Insurance Plan Phone#: _____

Group# (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Insured's ID# or S.S.#: _____

Insured's Employer: _____ _____

Employer's Address: _____

Secondary Insurance

Dental Coverage ☐ Yes ☐ No

Insurance Plan Name: _____

Insurance Plan Phone#: _____

Group# (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Insured's ID # or S.S. #: _____

Insured's Employer: _____

Employer's Address: _____

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Primary reason for seeing the dentist today? _____

_____

I want to improve my smile ☐ Happy with my smile ☐

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Provider List ☐ Location ☐ Internet ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Medical History Information

	YES	NO
Are you currently under any medical treatment now?	○	○
Have you ever been hospitalized for any surgical operation or serious illness?	○	○
Do You ***currently*** need antibiotic **Pre-Med** for dental appointments?	○	○

Allergies

- ○ Aspirin
- ○ Codeine
- ○ Latex
- ○ Metal
- ○ Sulfa
- ○ **NONE**
- ○ Barbiturates (sleeping pills)
- ○ Iodine
- ○ Local Anesthetic Allergy
- ○ Penicillin
- ○ Other Allergy: _____

Medications

List any medications you are currently taking and the correlating diagnosis: _____

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

YES	NO		YES	NO		YES	NO	
○	○	AIDS/HIV	○	○	Hay Fever/Allergies	○	○	Rheumatic Fever
○	○	ADHD	○	○	Headaches	○	○	Scarlet Fever
○	○	Anemia	○	○	Heart Murmur	○	○	Shortness of Breath
○	○	Arthritis, Rheumatism	○	○	Heart Problems	○	○	Sinus Trouble
○	○	Artificial Heart Valves	○	○	Hepatitis Type _____	○	○	Skin Rash
○	○	Artificial Joints	○	○	Herpes	○	○	Special Diet
○	○	Asthma	○	○	High Blood Pressure	○	○	Stroke
○	○	Back Problems	○	○	High Cholesterol	○	○	Swollen Feet or Ankles
○	○	Bleeding abnormally	○	○	Jaundice	○	○	Swollen Neck Glands
○	○	Blood Disease	○	○	Kidney Disease	○	○	Thyroid Problems
○	○	Cancer	○	○	Liver Disease	○	○	Tonsillitis
○	○	Chemical Dependency	○	○	Low Blood Pressure	○	○	Tuberculosis
○	○	Chemotherapy	○	○	Mitral Valve Prolapse	○	○	Tumor/growth on head/neck
○	○	Circulatory Problems	○	○	MS	○	○	Ulcer
○	○	Congenital Heart Lesions	○	○	Nervous Problems	○	○	Venereal Disease
○	○	Cortisone Treatments	○	○	Pre-Med with Antibiotics	○	○	Weight Loss, unexplained
○	○	Diabetes	○	○	Pacemaker			
○	○	Emphysema	○	○	Psychiatric Care/ Depression/Anxiety			
○	○	Epilepsy						
○	○	Fainting or dizziness	○	○	Radiation Treatment			
○	○	Glaucoma	○	○	Respiratory Disease			

Women:	YES	NO
Are you Pregnant	○	○
Due date _____		
Are you nursing?	○	○

Dental History

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

YES	NO		YES	NO	
○	○	Bad Breath	○	○	Loose teeth or broken fillings
○	○	Bleeding gums	○	○	Mouth breathing
○	○	Blisters on lips or mouth	○	○	Mouth pain, brushing
○	○	Burning sensation on tongue	○	○	Orthodontic treatment
○	○	Cigarette, pipe, or cigar smoking	○	○	Pain around ear
○	○	Clicking or popping jaw	○	○	Periodontal treatment
○	○	Dry mouth	○	○	Sensitivity to Cold
○	○	Fingernail biting	○	○	Sensitivity to Hot
○	○	Food collection between teeth	○	○	Sensitivity to Sweets
○	○	Foreign objects (piercings)	○	○	Sensitivity when biting
○	○	Gums swollen or tender	○	○	Smokeless Tobacco (Chew)
○	○	Jaw pain or tiredness	○	○	Sores or growths In mouth
○	○	Lip or cheek biting			

How often do you floss? _____ How often do you brush? _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change In my health, I will inform the doctors at the next appointment without fail. I understand that providing incorrect information can be dangerous to my health.

_____ Date: _____

Signature of Patient (Parent or Guardian)