WELCOME TO THE OFFICE OF
Dr. Jack Smalley, D.D.S. & Dr. Dawn K. Glover D.D.S.

PLEASE FILL OUT THIS FORM COMPLETELY

ABOUT YOU

Today's Date:_____ Please Check __Married __Single__ Divorced __Widowed __ Separated

Name:_____ Male__ Female__ Age_____ Date of Birth_____

SS#_____

Mailing Address_____

Home #_____ Cell # _____ Work # _____

E-Mail Address _____

Whom may we thank for referring you?_____

Employer_____ Work # _____

General Doctor_____ Date of last Visit_____

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CONTACT

Name_____ Relation_____ Number _____

SPOUSE INFORMATION

Name_____Birth Date_____ Contact #_____

PERSON RESPONSIBLE FOR ACCOUNT, IF OTHER THAN YOU

Name_____ Relation_____ SS#_____

Employer_____ Contact #_____ Date of Birth_____

Billing Address_____

INSURANCE INFORMATION

Primary Dental Company _____ Phone # _____

Group # _____ ID # _____ Address_____

Insureds Name_____ Date of Birth_____ SS# _____

Employer_____ Address_____

Secondary Dental Company _____ Phone # _____

Group # _____ ID # _____ Address_____

Insureds Name_____ Date of Birth_____ SS# _____

Employer_____ Address_____

Time 8:11 AM

Jack O Smalley, DDS, PC

Date 7/10/2017

Eaglesoft Medical History

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
Anaphylaxis	◯ 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	Genital Herpes	◯ 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:_____

Payment Policies for Our Office

- We will be happy to process claims for you to your insurance company, although any estimated patient portion is to be PAID IN FULL AT TIME OF SERVICE.
- We Do NOT accept MEDICAID
- We offer CARE CREDIT HEALTHCARE FINANCING. They have plans with smaller monthly payments and up to 12 months interest free financing for those who qualify. Their phone number is 1-800-365-8295. Approval is REQUIRED prior to your appointment.

Payment can be made by cash, check, money order--- We also MasterCard, Visa and Discover

Account balance that reaches 60 days past due will be charged an interest rate of 21%.

HIPAA Consent for use and Disclosure of Health Information

By signing this form, you consent to our use and disclosure of your protected health information to carry out your treatment, payment activities, and healthcare options. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. You may obtain a copy of our Notice of Privacy Practices at any time by contacting our office at 505-327-3331. I, _____, have had full opportunity to read and consider the consent of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent for I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal representative's name:_____

Relationship to patient:_____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist to the dentist's use and disclosure of my records to carry out treatment, to obtain payment, and those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records to the following persons who are involved in my care or payment for that care.
Name:_____ Relationship_____

I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services, and that I am financially responsible for payment in full of all account. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental carrier.

Patient or Guardian's Signature_____ Date_____

DENTAL HEALTH EVALUATION

1) Are you having problems with your teeth, or is anything bothering you at this time?
Yes__No__
If so what-_____

2) How long since you have last seen a dentist?_____

3) Are you pleased with the appearance of your teeth? Yes____No_____Is there anything you would like to change? Yes___No_____ Specific concerns or changes desired

_____

_____

4) Are your teeth as white as you would like them to be? Yes___No____

5) Do you pack food between any teeth while chewing? Yes___No_____

6)Are your teeth sensitive to Hot?_____ to Cold_____to Chewing_____

7) Are you aware of any problems with your gums? Yes_____No_____

8) Are your gums sore, or do the bleed when you brush / floss? Yes____No____

9) Do you have any missing teeth? Yes___No___ Has anyone suggested replacing them? Yes__No__
What was recommended?

_____

10) Are you apprehensive or uncomfortable about dental treatment? Yes___ No____

11) How do you feel about keeping your natural teeth for a lifetime?
High____Medium____Low____

12) In order of priority, which of the following would prevent you, -or- be a barrier to you, in considering dental treatment?

___ Fear of treatment itself
___ Time away from work
___ Financial concern
___ Lack of importance or concern for your teeth

Signature_____Date_____