Eastside Dental

FRANK R. GALKA D.D.S.
KURT G. BEHLMER D.D.S.

PATIENT INFORMATION...PLEASE PRINT

Date _____

Last Name _____ First Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Marital Status (Please Circle): M S D W

Gender (Optional): Male Female

Date of Birth _____ /_____ /_____ Age _____ Social Security Number _____

School/Employer _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Preferred Method of Contact: Text Email Phone Call

Emergency Contact: Name _____ Phone _____

Relationship to Patient: _____

RESPONSIBLE PARTY (if not patient)

Parent/Spouse Name _____ Date of Birth _____/_____ / _____

Address _____

Social Security Number _____ Employer _____

Phone Number _____ Method of Payment: Credit Card Check Care Credit Other

DENTAL INSURANCE INFORMATION

Primary Insurance _____ Subscriber _____

Relationship to Insurance Subscriber: Self Mother Father Guardian

Employer _____ Subscriber ID _____

Subscribers Social Security Number _____ Subscriber's Date of Birth _____ / _____ / _____

Group Number: _____ Insurance Phone Number _____

How did you hear about our office? Internet Search Facebook Mailing Advertisement

Patient _____ Other _____

Please List all other members of your immediate family who are patients in our office:

_____

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Office Phone _____ Date of last Exam _____

What is the nature of today's visit? Exam Consultation Emergency

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain *(joints, ear, side of face)*	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatments?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
Rate your smile on a scale 1-10		
1= Unhappy 10=Very happy _____		

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you drink alcohol?	☐	☐
9. Do you use controlled substances?	☐	☐
10. Are you wearing contact lenses?	☐	☐
11. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks)?	☐	☐
12. Are you allergic to or have any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other Allergies	☐	☐
13. Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

14. Do you have or have you had any of the following:

	Yes	No
AIDS/HIV positive	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Arthritis, rheumatism	☐	☐
Artificial heart valve	☐	☐
Asthma	☐	☐
Atopic *(allergy prone)*	☐	☐
Back problems	☐	☐
Blood disease	☐	☐
Cancer	☐	☐
Cardiac pacemaker	☐	☐
Chemical dependency	☐	☐
Chest pains	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent	☐	☐
Cough up blood	☐	☐
Diabetes	☐	☐
Epilepsy/convulsions	☐	☐
Emphysema	☐	☐
Fainting	☐	☐
Food allergies	☐	☐
Frequently tired	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart attack	☐	☐
Heart disease	☐	☐
Heart Murmur	☐	☐
Heart problems	☐	☐
Describe _____		
Hemophilia/abnormal bleeding	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
High blood pressure	☐	☐
Joint replacement or implant	☐	☐
Kidney problem	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Leukemia	☐	☐
Material allergies (Latex, wool, metal, chemicals)	☐	☐
Mitral valve prolapse	☐	☐
Nervous problems	☐	☐
Psychiatric care	☐	☐
Rapid weight gain/loss	☐	☐
Radiation treatment	☐	☐
Respiratory problem	☐	☐
Rheumatic/scarlet fever	☐	☐
Sexually transmitted disease	☐	☐
Shingles	☐	☐
Skin rash	☐	☐
Spina bifida	☐	☐
Stroke	☐	☐
Surgical implant	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid disease/malfunction	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcer/colitis	☐	☐
Venereal disease	☐	☐

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain _____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. A service charge of 1 1/2% per month *(18% per annual)* on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements satisfied. This office accepts insurance, and I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature of Patient *(or parent/guardian of minor)* Date