Easy Dental Care - 10/27/2022

Contact and Insurance

Patient Information

Preferred Name	Date of Birth	Gender	Address
City	State	Zip	Primary Phone
Other Phone	Email	Emergency Contact	Emergency Contact Phone Number

Billing and Insurance Information

Person Responsible for Bill	Phone Number	Address (if different)	City
State	Zip Code	Primary Insurance Carrier	Subscriber's Name
Patient's Relationship to Subscriber	Subscriber's Date of Birth	Subscriber's Social Security Number	Policy Number
Group Number		Insurance Company Phone	

Health History

Medical History

Do you currently have or have a history of any of the following?

Abnormal/Excessive bleeding	Acid Reflux	ADHD/ADD	AIDS/HIV
Anemia	Anxiety	Asperger	Arthritis
Asthma	Autism	Autoimmune disease	Bladder complications
Blood disease	Blood transfusion	Bone disorders	Breathing problems/respiratory disease
Bronchitis	Cancer	Cardiovascular disease	Cerebral Palsy
Chemotherapy/Radiation treatment	Chest Pain	Chronic Pain	Cleft lip/ Palate
Cold Sores/Herpes	Congestive heart failure	Convulsions	Damaged heart valves
Developmental delay	Diabetes	Down Syndrome	Ear Pain
Endocrine Problems	Emotional Disorders	Emphysema	Epilepsy
Fainting spells	Gastrointestinal disease	Glaucoma	Gout
Headaches	Hearing difficulties	Heart attack	Heart condition
Heart murmur	Heart rhythm disorder	Hemophilia	Hepatitis
Hypertension (High Blood Pressure)	Immune Problems	Joint Replacement	Kidney Disease
Liver problems	Low Blood Pressure	Lung Disease/COPD	Measles
Mouth breathing	Mumps	Muscular Disorders	Nervous Disorders
Organ Transplant	Osteoporosis	Pacemaker	Prolonged Bleeding
Rheumatic Fever	Rubella	Scoliosis	Seizures
Sinus Problems	Speech problems	Spinal Bifida	Thumb/Finger sucking
Thyroid	Tuberculosis	Ulcers	Any surgeries
Other, not mentioned			
Please explain any conditions you responded "yes" to			

Medications and Allergies

Medications and Allergies

Please list any medications (prescription and/or non-prescription) you are currently taking, including contraceptives, herbal supplements, or vitamins

<h4 data-bind-id="bs-db-7343">Do you have allergies to any of the following?</h4>

Acetaminophen	Amoxicillin	Animals	Aspirin
Codeine	Demerol	Environmental/Seasonal	Fluoride
Food	Ibuprophen	Iodine	Latex
Local Anesthetic	Morphine	Penicillin	Other, not mentioned above
If "yes" to any of the above, please explain			
<h4 data-bind-id="bs-db-7379">Pregnancy</h4>			
Were you pregnant in the last 90 days?	Are you currently pregnant?	How many weeks along?	
<h4 data-bind-id="bs-db-7388">Smoking Status</h4>			
Do you currently smoke?	Are you a former smoker?		
<h4 data-bind-id="bs-db-7394">Do you have a history or problems with any of the following?</h4>			
Bleeding Gums	Canker Sores	Cold Sores	Crowns/Bridges
Deep Cleaning/Periodontal (Gum) Treatment	Fillings	Implants	Oral Cancer
Root Canal Treatment	Sensitive Teeth	Tooth Extraction	Tooth Pain
Other (please specify)			

Signature

Signature

How'd you hear about us?

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Easy Dental Care or insurance company to release any information required to process my claims.

Date signed: