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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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:_____

NEW AGE DENTAL CARE
Family & General Dentistry

Getting To Know Our Guest

Name: _____ Date of Birth: _____

What name do you prefer to be called? _____

Address: _____

What is the best phone number to reach you? _____

What is your e-mail address? _____

How did you find out about our office? _____

What other media do you use for finding health care services? Check all that apply.

___Direct Mail ___Coupon Mailers ___Yellow Pages ___TV ___Radio ____Newspaper
___Magazine ___Internet Search Engine ___Family and Friends ____Referral from Doctor

Where do you work? _____ Phone Number: _____

Address: _____

Please share with us what you expect from us as your dental care providers.

What do you most want to achieve from your dental care?

What is the biggest concern you have about your dental health?

How would you describe your ideal smile?

How would you describe the perfect dentist?

Please rate the following in terms of importance **1=Least** and **5=Most**

Cost	1	2	3	4	5
Reputation	1	2	3	4	5
Takes My Insurance	1	2	3	4	5
Proximity to Home or work	1	2	3	4	5

EUGENIA KARDARIS D.D.S.

Family & Cosmetic Dentistry

FINANCIAL AGREEMENT

Thank you for choosing us as your dental health care provider. We are committed to providing the highest quality of dental care and continued maintenance of your oral health. Please understand that paying for your dental work is considered to be an integral part of your ongoing treatment. The following is a statement of our *Financial Agreement,* which we require you to read and sign prior to any treatment. **We require payment in advance of each scheduled appointment. We do offer a pre-payment discount for treatment plans that are paid in full. For patients with insurance it is our policy to collect the patient co-pay at the time we schedule your appointment.** For your convenience we accept cash, checks, VISA and MasterCard. We also offer an extended payment plan through the *independent credit companies* with credit approval. **There is a $25.00 charge for any returned checks.**

Regarding Dental Insurance

All co-pays and deductibles are due on the date of service. The balance is your responsibility whether your insurance company pays or not. Please remember, we submit insurance as a courtesy to you. You are responsible for all charges incurred in this office. Your ultimate reimbursement rests with your insurance company. At *New Age Dental Care* we strive for excellence in dentistry. As such, we are a mercury-free office. Insurance companies often offer an alternative benefit in paying for posterior composites. You are responsible for the difference in price of mercury containing and mercury free restorations. Please contact your individual insurance company for specifics on their compensation policy.

Minor Patients/ Students

The adult accompanying a minor and the parents (or guardian of the minor or student) are responsible for full payment. For unaccompanied minors or students, non-emergency treatment will not be provided unless the charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time services are rendered as well as the prior consent of the service to be provided to the minor.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments ($50.00 per scheduled hour). If *emergency situations* arise that prevents you from keeping your appointment, please let us know as soon as possible so we can reschedule your appointment. **No cancellations or changes to appointments will be accepted on the answering machine**. Please help us serve you better by keeping your scheduled appointments.
Thank you for your understanding our *Financial Agreement.* Please let us know if you have any questions or concerns.

I have read the *Financial Agreement,* and I understand and agree to its terms and conditions.

_____ _____

Signature of Responsible Party Date

NEW AGE DENTAL CARE
Family & General Dentistry

Eugenia Kardaris, D.D.S., P.C. and Associates, General Dentists

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Record Release

NAME_____ **DOB**_____

SSN_____

I agree to have my dental records released from New Age Dental Care and Dr. Eugenia Kardaris to be sent to another dentist.

By signing this document I acknowledge my release from New Age Dental Care and Dr. Eugenia Kardaris and will have all x-rays sent to provider indicated:

_____
Dentist Name

_____
Address

_____
Phone #

_____ _____
Patient Signature Date