Jeffory M. Eaton, D.D.S.

Date: ____________________

Patient Name:____________________________________DOB _____________________ □ Male □ Female

Social Security #_________________________________ □ Married □ Single □ Divorced □ Minor under 18

Home Address:____

Street City State Zip Code

Phone#________________________ Cell #______________________Work# _____________________

E-mail____ Drivers License # ________________________

Employer Name: ____Occupation ______________________

Address: ____

Street City State Zip Code

Spouse Information

Spouse Name:____ DOB______________________

Social Security #:____________________Phone #:___________________ Cell #_____________________

Employer:____Occupation________________

Address:____

Street City State Zip Code

Primary Insurance

Insurance Name:____Phone __________________________

Address: ____

Street City State Zip Code

Subscriber Name: _________________________________S.S. #_____________________ DOB _______

Subscribers Employer: ____

Group# ____________________________ Relationship to insured ________________________________

Secondary Insurance

Insurance Name:____Phone __________________________

Address: ____

Street City State Zip Code

Subscriber Name: _________________________________S.S. #_____________________ DOB _______

Subscribers Employer: ____

Group# ____________________________ Relationship to insured ________________________________

How did you hear of our office?____

Our office is HIPAA compliant and is committed to meeting the standards of infection control mandated by OSHA, the CDC and the ADA

I affirm the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of medical information to the insurance company(s) or their designated representatives, treating physician(s) and physicians to whom I am referred. My signature below also acknowledges that I have received a copy of this dental practices Notice of Privacy Practices (HIPAA) and allows for assignment of benefits to this dental practice. I have read and understand the consent to perform dentistry, and my signature below gives consent to this office to perform dentistry as needed. A photocopy of this assignment is to be considered as valid as the original, and I understand that I am financially responsible for all my dental treatment. This order shall remain in effect until revoked by me, in writing.

Signature: ____ ***Date:*** ____________________

Jeffory M. Eaton, D.D.S.

Please check Y or N for all of the following health problems:

Y	N		Y	N		Y	N		Y	N	
◊	◊	Anemia	◊	◊	Cortisone	◊	◊	Hepatitis	◊	◊	Scarlet Fever
◊	◊	Arthritis	◊	◊	Cough	◊	◊	High Blood Pressure	◊	◊	Shortness of Breath
◊	◊	Skin Rash	◊	◊	Artificial Heart Valve	◊	◊	HIV/AIDS	◊	◊	Artificial Joints – Prosthetic Implants
◊	◊	Diabetes	◊	◊	Jaw Pain	◊	◊	Stroke	◊	◊	Asthma
◊	◊	Epilepsy	◊	◊	Kidney Disease	◊	◊	Swelling of feet	◊	◊	Back Problems
◊	◊	Fainting	◊	◊	Liver Disease	◊	◊	Thyroid Problems	◊	◊	Blood Disease
◊	◊	Glaucoma	◊	◊	Mitral Valve Prolapse	◊	◊	Tobacco Habit	◊	◊	Cancer
◊	◊	Headaches	◊	◊	Pacemaker	◊	◊	Tonsillitis	◊	◊	Chemical Dependency
◊	◊	Heart Murmur	◊	◊	Radiation Treatment	◊	◊	Tuberculosis	◊	◊	Chemotherapy
◊	◊	Heart Problems	◊	◊	Respiratory Disease	◊	◊	Ulcer	◊	◊	Circulatory Problems
◊	◊	Hemophilia	◊	◊	Venereal Disease	◊	◊	Low Blood Pressure	◊	◊	Psychiatric Problems

Are you allergic to any of the following (Circle): **Aspirin** **Codeine** **Erythromycin** **Tetracycline** **Latex** **Sulfa Drugs** **Penicillin** **Sedatives** **Barbiturates** **Dental Anesthetics**

List any additional allergic reactions you have had ____

List all prescription/over the counter medications you are taking ________________________________

____

Are you currently under the care of a physician? Explain ______________________________________

Physician's Name ____ Phone ____________________

FOR WOMEN: are you pregnant? _______ # Weeks ____________Do you take birth control pills ________

Bisphosphonate usage: (Boniva, Fosamax, Reclast) No ____ Yes______________________________________

Former Dentist_____________________________________ Date of last visit ____________________

Phone: ____

How often do you brush? ___________ Floss _______________ do you smoke? ______________ How much _____

Do you have any of the following concerns (circle)?

Hot/Cold sensitivity Sores or Growths in mouth loose teeth popping in jaw

Grinding your teeth Bad breath bleeding gums

Have you ever had Periodontal Disease? _________________ Do you still have wisdom teeth? _____________

Are you happy with your smile? ___________If no, what would you like to change? ______________________

Any other concerns you would like to bring to the Doctors attention today. ______________________________

Do you require antibiotics before dental treatment? ___________ If yes, have you taken any today? ______

Reason for today's visit____

Signature:____ Date: ____________________

Reviewed by: ____ Date:______________________

Consent to Perform Dentistry - Assignment of Benefits – Authorization to Release Information - Financial Responsibility

- I hereby authorize Dr. Jeffory M. Eaton and other providers in his office to take radiographs, study models, photographs and any other study aides deemed necessary to make a diagnosis. Upon diagnosis I also authorize Dr. Eaton to perform all recommended treatment mutually agreed upon, that is required for proper care.

- I agree to the use of anesthetics, sedatives or other medication as necessary. I fully understand that using anesthetics embodies certain risks. I have been told the risk of any complications, and I consent to the treatment required for proper care.

- I authorize this office to use my patient information to verify insurance benefits, submit electronic claims and receive other information over secured websites. I understand that Jeffory M. Eaton and his staff are not liable for any charges, damages or losses that may be incurred or suffered by me by any misuse or theft of my personal information.

- I authorize the release of medical information to the insurance company(s) or their designated representatives, treating physician(s) and any physicians to whom I am referred.

- I understand that I am financially responsible for all my dental treatment.

- My signature below allows assignment of benefits to Jeffory M. Eaton, a photocopy of this assignment is to be considered as valid as the original. This order shall remain in effect until revoked by in writing.

Notice of Privacy Practices (HIPAA)

- My signature below also acknowledges that I have received a copy of this dental practice Notice of Privacy Practices (HIPAA) I hereby acknowledge that I have received and reviewed a copy of Jeffory M. Eaton, DDS's *HIPAA Notice of Privacy Practices*. I am entitled to receive a copy of all revised *HIPAA Notice of Privacy Practices* upon request. I understand that, if I have questions about the office's *HIPAA Notice of Privacy Practices*, I may contact Lynn Airola at (650)345-5300.

- I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Jeffory M. Eaton, DDS's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Lynn Airola noted above, for assistance.

Patient Signature: ___________________________________ **Date:**____________________

Consent for Internet Communications

Date: ________________________

Patient Name:____

Email Address: ____

Cell Phone # (for text messages)____

I grant my permission to Jeffory M. Eaton, DDS to upload and store confidential patient information including account information, appointment information and clinical information to the secured website for Jeffory M. Eaton, DDS. I understand that for security purposes, the site requires a user ID and password for access and use. I also understand Jeffory M. Eaton, DDS will be responsible for maintaining the strict confidentiality of any ID and password assigned; and that Jeffory M. Eaton, DDS is not liable for any charges, damages, or losses that may be incurred or suffered as a result of failure to maintain confidentiality. I understand Jeffory M. Eaton, DDS is not liable for any harm related to the theft of any ID and password, disclosures. I also understand State and Federal laws, HIPAA, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Jeffory M. Eaton, DDS will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Jeffory M. Eaton, DDS has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Jeffory M. Eaton, DDS will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded. I understand Jeffory M. Eaton, DDS CAN NOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED; MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES. I have read the information above regarding the secured uploading of patient information to the internet for Jeffory M. Eaton, DDS and grant Jeffory M. Eaton, DDS permission to securely upload my patient information.

____ Date: ______________________

Signature of patient, parent or guardian