PATIENT UPDATE & CONSENT FOR DENTAL TREATMENT

Date_____

Patient Name _____ DOB_____ S.S./ID# _____

Email address: _____

Best Phone # to reach you_____

If no change check here _____

Mailing Address _____

Cell Phone_____ Home Phone _____ Work Phone_____

If no change check here _____

Dental Insurance_____ Phone _____

Subscriber _____ Subscriber ID# _____ DOB _____

Please give us a copy of your insurance card, and we will make a copy

PLEASE COMPLETE THE FOLLOWING COMPLETELY

Do you have any of the following?

☐ Sensitive teeth	☐ Loose teeth	☐ Bleeding gums	☐ Missing teeth
☐ Bad breath	☐ Cold sores	☐ Jaw pain	☐ Dry mouth
☐ Broken filings	☐ Gum Infection	☐ Swollen Glands	☐ Grinding

FOR WOMEN: are you pregnant? __ # Weeks _____ Do you take birth control pills _____

Bisphosphonate usage: (Boniva, Fosamax, Reclast) No _____ Yes _____

List all medications you are taking _____

_____

List any health changes since your last visit _____

Are you allergic to any medication? _____

Do you require antibiotics before dental treatment _____ if yes, have you taken it today? ____

Reason for seeking dental care at this time _____

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.

Patient Signature _____ Date _____

Staff Signature_____ Date_____