



EWING
DENTAL ASSOCIATES

Welcome

Thank you for selecting Ewing Dental Associates!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out
this form completely in ink. If you have any questions or need
assistance, please ask us - we will be happy to help.

Patient Information

Date _____

Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____

SS # _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Check Appropriate Box: Minor Single Married Patient's Sex F M

Patient Employer _____

Spouse or Parent/Guardian's Name _____

Person to Contact in Case of Emergency _____ Phone _____

How Did You Hear About Our Office? _____

Whom May We Thank for Referring You? _____

Dental Insurance Information

Insurance Company _____ Group # _____ ID# _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____

Name of Employer _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Insurance Company _____ Group # _____ ID# _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____

Name of Employer _____

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature - Patient / Guardian _____ Date _____

Patient Medical History

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:		YES	NO	YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	20. thyroid or parathyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to			21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			22. high cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			23. diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems _____	<input type="checkbox"/>	<input type="checkbox"/>	32. neurologic problems _____	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	46. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	47. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	48. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
			49. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any current pain with your teeth? YES NO
 If yes, please explain: _____

Do you have any other dental concerns: YES NO
 If yes, please explain: _____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____