Welcome to the office of Dr. Tate Eble

Patient Name: _____Sex (M or F) _____Date_____
Address: _____
Street/City/State/Zip Code
Marital Status: _____ Birth Date _____ Social Security #_____
Phone (Home#) _____ (Cell#) _____ (Work#) _____
Employer Name _____ Occupation_____
Are any other immediate family members patients here? _____ If so, who? _____
Emergency Contact _____ Phone (Home#) _____ (Cell#) _____

Insurance Information

Subscriber Name _____ SS#_____ Birth Date _____
Insurance Company _____ Group Number _____ Phone _____
Mailing Address _____ Effective Date _____
Person responsible for the account _____ Relationship _____
Address _____
Street/City/State/Zip Code
Phone (Home #) _____ (Cell#) _____ (Work#) _____

Health Information

Do you have any of the following conditions? Please check those that apply:

____ Allergies	____ Epilepsy	____ HIV Positive/AIDS	____ Pregnancy
____ Anemia	____ Glaucoma	____ Kidney Disease	____ Penicillin Allergy
____ Taking Aspirin	____ Heart Attack	____ Liver Disease	____ Respiratory Problems
____ Artificial Joints	____ Heart Disease	____ Mental Disorders	____ Rheumatic Fever
____ Arthritis	____ Heart Murmur	____ Mitral Valve Prolapse	____ Sinus Problems
____ Cancer	____ Hepatitis	____ Nervous Disorders	____ Tuberculosis
____ Diabetes	____ High Blood Pressure	____ Pace Maker	

Do you have any conditions or illnesses not listed above? _____ If so, please list them below.
_____

Are you currently taking any over-the-counter or prescription medications? _____
If so, please list them. _____

Circle any of the following medications you may be allergic to:

Aspirin	Darvocet	Valium	Novocaine	Xylocaine	Darvon
Erythromycin	Penicillin	Tetracycline	Percodan	Codeine	

If any, what other medications are you allergic to? _____

Personal Information

Have you ever had a bad experience at the dentist? _____
When was your last dental visit? _____What is the reason for this visit? _____
When were x-rays last taken of your teeth? _____
How frequently do you brush your teeth? _____ Soft or Hard bristle toothbrush? _____

Do you have concerns regarding your teeth? _____

Yes	No	Have you had periodontal treatment?	Yes	No	Do you clench or grind your teeth?
Yes	No	Do you use tobacco products?	Yes	No	Do you have frequent headaches?
Yes	No	Do you have a click or pop in your jaw joint?	Yes	No	Are your teeth sensitive to hot or cold?
Yes	No	Are any teeth uncomfortable when biting down?	Yes	No	Would you like info on teeth whitening?
Yes	No	Do your gums bleed when you brush or floss?			

Payment Terms

Payment is due in full at time of treatment unless prior arrangements have been approved. If you do not pay your account, the person responsible for payment will pay all expenses in order to collect your account balance including all court costs and attorney's fees.

We accept Visa, MasterCard, Discover, and Care Credit.

This account will be handled by: ____ Cash ____ Credit card ____ Check ____ Care Credit

I have read and answered the above questions to the best of my knowledge. I authorize and request my Insurance Company to pay directly to the Dentist. I authorize my doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of this signature on all Insurance submissions.

_____ _____
SIGNATURE OF PATIENT OR PARENT IF MINOR. DATE