Addendum

Patient Name: _____ DOB: _____

Check (√) if you are currently experiencing problems with the following:

□ Bad breathe
□ Bleeding gums
□ Clicking or popping in jaw
□ Food collection between teeth
□ Grinding or clenching teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to hot
□ Bite nails
□ Moth Breather
□ Bulimia/Anorexia
□ Thumb/ Finger Sucker
□ Tongue Thrust
□ Broken teeth
□ Special diet
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in your mouth

Soda □ Yes □ No
If yes, how much? _____

Cigar/Cigarette/Pipe □ Yes □ No
If yes, how much? _____

Periodontal Treatment □ Yes □ No
If yes, how much? _____

What type of toothpaste do you use?
_____

How often do you brush? _____

I have a: Electrical toothbrush □
Manual tooth brush □

Reason for today's visit: _____
_____

Date of last dental care? _____

Gum □ Yes □ No
If yes, how much? _____

Smokeless Tobacco □ Yes □ No
If yes, how much? _____

Would you like whiter teeth? □ Yes □ No

What type of mouthwash do you use?
_____

How often do you floss? _____

Is there anything about your smile that you would like to change? _____
_____

Former Dentist: _____

Date of last dental x-rays? _____

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintain your dental health.

Patient Information:

Today's Date: _____

Name: _____

Preferred or Nick Name: _____

Date of Birth: _____ Age: _____

Social Security Number:_____

Male □ Female □

Married □ Single □ Separated □ Widowed □

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Emergency Contact: _____
Emergency Contact's Phone #:_____

*IF PATIENT IS A MINOR:

Mother's Names: _____
Mothers' Cell: _____

Father's Name: _____
Father's Cell: _____

Insurance Information:

Policy Holder:_____

Date of Birth: _____

Social Security Number: _____

Relationship to Patient: _____

Employer:_____

Insurance Company: _____

Member ID: _____

Secondary Insurance:

Policy Holder:_____

Date of Birth: _____

Social Security Number: _____

Relationship to Patient: _____

Employer:_____

Insurance Company: _____

Member ID: _____

How did you hear about us?

Family/Friend □ Insurance □ Internet □
Doctor Referral □

Name of referral: _____

Time 2:08 PM

Date 7/25/2022

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, c

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:

o 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 esponsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Austin Rickabaugh D.D.S

8615 Rosehill Rd * Lenexa, KS 66215

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to the restrictions
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we discuss any dental matter with any other individual? □ Yes □No

If YES, please list all the names of the individuals we can talk to on your behalf:

_____ _____

_____ _____

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

Payment Policy

We accept the following forms of payment: Cash, Credit Card, Third-party financing through Care Credit and our in office plan.

We will file your insurance as a courtesy to you. **ESTIMATED** copay is due the day of service.

We work 100% for you, not the insurance company. We do not compromise our standards by offering anything less than the care you deserve. As the cost of quality health has risen, most insurance reimbursements have remained relatively flat. Therefore, most dental procedures have out–of-pocket co-pays. Our fees are determined on the care, judgement and skill of the provider.

Please initial:

_____ I understand payment is due on the date of service

_____I understand I am responsible for the full fee regardless of insurance.

_____I understand the estimated co-pay is only an estimate and I owe any balance left after insurance pays.

_____I understand that it is my responsibility to inform your office of any insurance

Signature: _____ Date: _____

I authorize Austin Rickabaugh DDS to submit to my insurance Company and I authorize my Insurance Company to pay Austin Rickabaugh directly.

Signature: _____ Date: _____