

Welcome

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Thank you for choosing our practice for your dental needs. Please complete this form in ink.

Patient Information

Form with fields: First Name, Middle, Last Name, Date, Physical Address, City, State, Zip, Mailing Address, Home Phone, Work Phone, Cell Phone, Email Address, Birth date, Age, SS#, Marital Status, If full-time student, name of school, City, State, Patient or parent's employer, Occupation, Business Address, City, State, Zip, Person to contact in case of emergency, Relationship, Phone, Name of closest relative not living with you, Relationship, Phone, How did you hear about our office?.

Responsible Party

Form with fields: Name of person responsible for this account, Phone, Relationship to patient, Employer, Phone, Address, City, State, Zip.

Primary Dental Insurance (Please have card available)

Form with fields: Name of insured, Relationship to patient, Birth date, SS#, Date of employment, Name of employer, Phone, Business Address, City, State, Zip, Insurance Co., Group#, Insurance ID #, Insurance Address, City, State, Zip.

Secondary Dental Insurance (Please have card available)

Form with fields: Name of insured, Relationship to patient, Birth date, SS#, Date of employment, Name of employer, Phone, Business Address, City, State, Zip, Insurance Co., Group#, Insurance ID #, Insurance Co. Address, City, State, Zip.

Authorization

I affirm that the information 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 authorize the dental staff to perform the dental services deemed necessary by the doctor and staff. I authorize assignment of insurance benefits to this office. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship to Patient Date

Privacy Policy

I affirm that I have read the Notice of Privacy Practices for this office as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that I may ask for a copy to take home.

Signature of Responsible Party Relationship to Patient Date

Patient Name: _____ DOB: _____ Date: _____

Dentistry plays an important role in your overall medical health. Thank you for answering the following questions.

Preferred Pharmacy: _____ City: _____

1. Are you currently under the care of a physician? Yes No

If yes, please explain _____

Physician Name: _____ Tel: _____

2. Are you currently taking any medications and/or vitamins? Yes No

If yes, please list _____

Additional Medication List Attached

3. Do you take medication for osteoporosis or osteoarthritis? Yes No

If yes, please list _____

4. Are you **allergic** to have you had **any reaction** to the following (Please check the box)?:

- | | | | | |
|---------------------------------------|--------------------------------------------|--------------------------------------------|-----------------------------------------|--------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Ibuprophen |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Metals | <input type="checkbox"/> Latex | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Aspirin |

Other : _____

5. Please indicate if **you have or have had** any of the following:

- | | | |
|----------------------------------------------------|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Excessive Dry Mouth | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease/Trouble | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stomach/Intestinal Disorders |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hives/Rash | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tonsil/Adenoid Surgery |
| <input type="checkbox"/> Cortisone Medications | <input type="checkbox"/> Implants –Cosmetic | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Lung Problems/COPD | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lupus | |

Do you have any disease, condition or health problem not listed above? If so, please list:

Signature: _____

Date: _____

Health History

- 6. Do you use tobacco? Yes No
- 7. Do you use or have you ever used controlled substances? Yes No
- 8. Have you ever taken Phen-Fen or Redux? Yes No
- 9. Are you on a special diet? Yes No
If yes, please explain _____
- 10. Have you ever been hospitalized or had a major surgery? Yes No
If yes, please explain _____
- 11. Have you ever had a serious head or neck injury? Yes No
If yes, please explain _____
- 12. Have you been diagnosed with sleep apnea? Yes No
If yes, do you use a sleep aid device? Yes No
- 13. Do you (please circle)?: Snore Clench/grind teeth Have trouble sleeping Wake up tired
- 14. **Women Only:**
Are you pregnant/trying to get pregnant? Yes No
If yes, when is your due date _____
Are you nursing? Yes No
Are you using birth control pills, patches or injections? Yes No

Dental History

- Reason for today's visit: _____
- When was your last dental cleaning/exam/x-rays? _____
- When was your last dental visit? _____ Reason _____
- Previous Dentist: _____ City/State _____
- Have you ever been told that you require pre-medication for dental procedures? Yes No
- Have you ever been diagnosed with periodontal disease? Yes No
- Have you ever had periodontal surgery? Yes No
If yes, when/type _____
- Have you ever had difficult extractions? Yes No
- Do you have dental implants? Yes No
- Are your teeth sensitive to heat and/or cold? Yes No
- Are your teeth sensitive to sweet/sour foods? Yes No
- Do your teeth hurt when chewing? Yes No
- Do you floss regularly? Yes No
- Do you use fluoride treatments at home? Yes No
- Have you ever been diagnosed with TMJ disorder? Yes No
- Have you ever been treated for TMJ disorder? Yes No
- Have you had your 3rd molars (wisdom teeth) removed? Yes No
- Do you wear dentures or partials? Yes No
When were they placed _____
- Have you ever had orthodontic treatment? Yes No
- Are you happy with your smile? Yes No
- If you could change anything about your smile what would it be?

Signature: _____

Date: _____

Office Policy

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(Please initial)

_____ **Appointments:**

In order to offer our patients the highest quality of care while maintaining affordable treatment fees, we request a minimum of 24 hours notice to change or cancel appointments. We understand that emergencies arise and will do our best to accommodate your needs. A cancellation fee may be charged for cancellation of appointments without 24 hour notice. For appointments requiring large blocks of time, you may be asked to guarantee your appointment with a credit card or check.

_____ **Insurance:**

We are pleased to file insurance claims on your behalf. The estimated portion of the treatment fee and any applicable deductibles will be due at the time of service. Any claims not paid by the insurance carrier within 90 days become the full responsibility of the insured. Secondary insurance will be filed also, however the patient will be responsible for fees estimated with primary coverage only. Any payment made by secondary carrier will be reimbursed directly to the insured. It is the responsibility of the insured to inform our office of any changes in insurance and to provide the insurance carrier with any requested information on coverage.

_____ **Prescriptions:**

Occasionally you may be prescribed medication prior to or following dental work. For your safety and the safety of others, the following policies apply:

- Prescriptions will not be refilled when the doctor does not have your records available. This might be weekends, after normal business hours or holidays.
- Please allow 24-48 hours for refill authorization following your request. Requests made over weekends, holidays, or after normal business hours will be addressed 24-48 hours from the next business day following the request.
- Prescriptions that have been lost, stolen or incorrectly taken will not be refilled.
- Prescriptions will not be refilled if you cancelled or failed your last appointment or did not follow through with recommended dental/medical treatment.
- During the time of your care in this office, only one doctor will be the source for your pain medication. You may still receive prescriptions such as antibiotics, etc. from other physicians but only one doctor should be prescribing pain medication. In the event that we feel pain medication is being over used, we will contact other physicians and pharmacies involved in patient care to request a prescription history.
- We reserve the right to terminate the doctor-patient relationship in the event of any breach in policy by the patient.

_____ **Cell Phones:**

Due to the highly sensitive nature of the advanced dental equipment used in our office, it is necessary for cell phones be turned completely off (not just on silent or vibrate) prior to entering treatment areas. If you are waiting for an urgent call, please notify our staff and they will happily monitor your phone at the front desk.