Eckman Family Dentistry

Dr. Joseph F. Eckman, Jr., D.M.D and Associates

687 Unionville Road/Kennett Square, PA 19348
610-444-0750/610-444-3835 (fax)
efdks0750@gmail.com

1 Commerce Blvd/West Grove, PA 19390
610-345-1125/610-345-1749 (fax)
efdjv1125@gmail.com

HEALTH HISTORY

Date ______________________ Patient Name _____________________________ Name you wish to be called _______________
Physical Address ____ Home Phone _______________________
City _________________________________ State ______ Zip Code ______________ Work Phone ______________________
Mailing Address ____ Cell Phone ________________________
City _________________________________ State ____ Zip Code ______________
Preferred Method to Reach You Live and In Person: Cell ___ Text ___ Email ___ Work ___ Home ___
Sex: ☐ M ☐ F Age _________ Birthdate _____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient SS # __________________________ Employer ___________________________
Employer Phone ______________________________
Email Address ____________________________________
Emergency Name ____________________________________ Number________________________________

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Responsible Party for Minor
Name ____ Relationship to minor ____________________________
Address ____
Phone Number _____________________________ Cell _________________________ Email _______________________________
Whom may we thank for referring you? ____

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Insurance Company ____ Group # __________
Is patient covered by additional insurance? ☐ yes ☐ no Subscriber's name ____
Subscriber's Birthdate _______________ Subscriber's SS# ________________________ Relationship to Patient ____________
Insurance company ____ Group # __________

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________________ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ _____________________________ _________________________
Responsible Party Signature Relationship Date

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DENTAL HISTORY

Reason for today's visit ____
Former Dentist ____ Phone# ____
Date of last dental visit _________________________________ Date of last dental X-rays ______________________________

Please check Yes or No to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	**Bleeding/Swollen gums**	☐ Yes ☐ No	**Blisters on lips or mouth**	☐ Yes ☐ No
Food collection	☐ Yes ☐ No	**Sensitivity to cold**	☐ Yes ☐ No	**Grinding teeth**	☐ Yes ☐ No
Mouth breathing	☐ Yes ☐ No	**Loose/Broken Teeth**	☐ Yes ☐ No	**Sores or growths in**	☐ Yes ☐ No
Periodontal Disease	☐ Yes ☐ No	**Dry mouth**	☐ Yes ☐ No	**Smoker/Chewing**	☐ Yes ☐ No
Clicking or popping Jaw	☐ Yes ☐ No	**Sensitivity to cold**	☐ Yes ☐ No	**Orthodontic treatment**	☐ Yes ☐ No
		Sensitivity to heat	☐ Yes ☐ No		

Have you ever had a serious or difficult problem associated with previous dental work

Do you pre-medicate prior to a dental visit /yes/no
Weight__________________________ Blood Pressure________________________________

MEDICAL HISTORY

Physician's Name ____ Date of last visit ____________________________
Please check yes or no to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No
Artificial heart valves ☐ Yes ☐ No
Artificial Joints ☐ Yes ☐ No
Date of Replacement_____________
Asthma ☐ Yes ☐ No
Bleeding abnormally ☐ Yes ☐ No
(with extractions or surgery)
Blood Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Circulatory problems ☐ Yes ☐ No
Cataracts/Eye Implants /Yes/ No
Cough,Persistent/Bloody /Yes/No
Diabetes ☐ Yes ☐ No
Heart Conditions /Yes/ No
List:__________________________
____
____
____
____

Epilepsy ☐ Yes ☐ No
Fainting or dizziness ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart Problems ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Type A/B/C
Herpes ☐ Yes ☐ No
Kidney Disease /Yes/ No
High Blood Pressure ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Ulcer ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Scarlet Fever ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Skin Rash ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Swollen Neck Glands ☐ Yes ☐ No

Thyroid Problems ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No

Women:
Are you pregnant? ☐ Yes ☐ No
Due date ___________
Are you nursing? /Yes/ No
Taking birth control? ☐ Yes ☐ No

Have you traveled outside of the U.S. within the last 12 months? If so list the Country below.____________________________

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MEDICATIONS

Please list medications you are currently taking:
____
____
____
____
Pharmacy Name __________________________
Phone ___________________________________

ALLERGIES

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other ____________
____

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.
I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

____ ________________________
Patient's Signature Date

____ ________________________
Doctor's Signature Date

(I have read, agree to, and understand the statements listed above)