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 maintaining your dental health.

Patient Information:

Today's Date:_____

Name:_____

Preferred or Nick Name:_____

Male:_____ Female:_____

Married:___Unmarried:___Separated:___Widowed:_____

Address:_____

City:_____

State:_____Zip:_____

Home Phone:_____

Cell Phone:_____

Email:_____

Date of Birth:_____Age:_____

Social Security Number:_____

Empolyer:_____

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

***If Patient is a Minor:**

Mother's Name:_____
Mother's Cell:_____

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

Insurance Information:

Policy Holder:_____

Relationship to Patient:_____

Employer:_____

Insurance Company:_____

Date of Birth:_____

Social Security Number:_____

Secondary Insurance:

Policy Holder:_____

Relationship to Patient:_____

Employer:_____

Insurance Company:_____

Date of Birth:_____

Social Security Number:_____

How Did You Hear About Us?

Phone Book, Insurance, Doctor Referral,
Internet, A Friend

Name of Friend:_____

James T. Voorhees D.D.S.

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:

To 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 responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Addendum

PATIENT NAME _____ **Birth Date** _____

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

- □ Bad Breath
- □ 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
- □ Mouth 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? _____

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

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

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

Periodontal Treatment □ Yes □ No
If yes, how long ago? _____

Would you like whiter teeth? □ Yes □ No

What type of toothpaste do you use?
_____

What type of mouthwash do you use?
_____

How often do you brush? _____

How often do you floss? _____

Do you have a manual or electric toothbrush?
_____

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

Reason for Today's Visit _____
_____

Former Dentist _____

Date of last dental care? _____

Date of last dental x-rays? _____

Payment Policy

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

We will file your insurance as a courtesy to you. ESTIMATED Co-pay 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:

1. I understand payment is due on the date of service_____
2. I understand I am responsible for the full fee regardless of insurance_____
3. I understand the estimated co-pay is only an estimate and I owe any balance left after insurance pays_____
4. I understand that it is my responsibility to inform your office of any insurance_____

Signature:_____Date:_____

I authorize James T. Voorhees, DDS to submit to my Insurance Company and I authorize my Insurance Company to pay James T. Voorhees directly.

Signature:_____Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

James T. Voorhees D.D.S.

8615 Rosehill Road * Lenexa, KS 66215

You May Refuse to Sign This Acknowledgement

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

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be contained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

_____

_____

_____

_____.