



Patient Information and Registration

Patient's Name _____ Date _____
How would you like to be addressed? _____
Gender _____ Marital Status _____ If married, name of spouse _____
Birthday _____ Social Security # _____
Street Address _____
City _____ State _____ Zip Code _____
How long have you been at this address? _____

Email Address _____

Are you responsible for this account? Yes No
If no, please provide the following information for the responsible person:
Name _____ Relationship to you _____
Address, if not the same _____
Birthday _____ Social Security # _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____

Dental Insurance Information

Insured's Name _____
Insured's Birthday _____ Insured's Social Security # _____
Insured's Employer _____ Occupation _____
Insurance Company Name _____ Group# _____
Insurance Company Address _____

Emergency Contact Information

Name _____ Relationship to you _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone _____

How did you find out about our office? (Please answer all that apply)
Personal referral from: _____
Professional referral from: _____
Internet _____ Newspaper Ad _____ Other _____

If you found us on the internet, what search words did you use? _____

Please fax these forms to our office (231-347-6141) two days prior to your visit, or mail them to D. Scott Eaton, D.D.S., 4144 Charlevoix Ave, Petoskey, MI, 49770

Any questions that we may address before your visit, please call us at 231.347.5055

D. SCOTT EATON, DDS

EXCEPTIONAL SMILES

Health and Dental History

Patient's Name _____

Physician's Name _____ Phone# _____

Are you taking any medications including daily aspirin? Yes No

If yes, please list name and dosage _____

Have you or are you taking Bisphosphonates (ex. Fosamax, Boniva, etc)? Yes No

Are you allergic to any medication or substance?

If yes, please list _____

Have you been under the care of a medical doctor during the past 2 years? Yes No

If so, for what? _____

Have you ever had any surgeries? Yes No

If so, please list _____

Have you seen an ENT (ear, nose and throat doctor)? Yes No

Name: _____

Have you seen a chiropractor? Yes No Name: _____

Have you seen a neurologist? Yes No Name: _____

Have you had braces? Yes No Name: _____

Have you ever had any cosmetic procedures? Yes No

Indicate which of the following you have had, or have at the present. Circle one.

Heart Concerns	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No
High Blood Pressure	Yes	No	Limited Opening (Jaw)	Yes	No
Mitral Valve Prolapse	Yes	No	Congested Ears	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No
Pacemaker	Yes	No	Ringing Ears	Yes	No
Stroke	Yes	No	Loose Teeth	Yes	No
Asthma	Yes	No	Posture Problems	Yes	No
Liver Disease/Jaundice	Yes	No	Clenching	Yes	No
Artificial Joints	Yes	No	Facial Pain	Yes	No
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No
Radiation/Chemotherapy	Yes	No	Neck Ache	Yes	No
Epilepsy/Seizures	Yes	No	Bell's Palsy	Yes	No
Diabetes	Yes	No	Sickle Cell Disease	Yes	No
Hepatitis	Yes	No	Difficulty Swallowing	Yes	No
AIDS/HIV	Yes	No	Difficulty Chewing	Yes	No
Trigeminal Neuralgia	Yes	No	Neuralgic Disorders	Yes	No
Tingling in arms/fingers	Yes	No	Psychiatric/Psychological	Yes	No
Osteoporosis	Yes	No	Cancer	Yes	No
Insomnia/Frequent Waking	Yes	No	Other: _____		

D. SCOTT EATON, DDS

EXCEPTIONAL SMILES

Does floss shred when you use it? Yes No
Does food pack or catch between your teeth? Yes No
Do you smoke or chew tobacco? Yes No
Do your gums bleed? Yes No
Does your breath concern you? Yes No
If so, for what? _____

Women, are you: Pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

Our office is like no other dental office. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never discussed or considered before. Please consider the following questions.

Are you having any areas of concern? _____
In your opinion, what do you think is your present state of oral health? _____
What are your expectations of today's visit? _____

How do you feel about your face and your smile? _____
Tell us about your past dental experiences, good or bad? _____

Has fear ever been an issue for you in a dental office? _____
Is time a big factor for you in getting dental work done? _____

Cost of dental care is often a concern. What can we do to help with this? _____

Is there any additional information you would like us to know? _____

Is there any questions that we may address for you immediately? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature _____ Date _____

Social Security Number _____ Date of Birth _____

Email Address _____



Comfort Menu

Your comfort is important to us. We provide many services to ensure that you are relaxed and comfortable during treatment. Please select from the following options:

**Patients find that if they take an analgesic prior to treatment, it helps later in the day. If you would like one, which do you prefer? Tylenol Advil other_____

**Watching TV, a favorite movie or listening to music can help pass the time during treatment. Each of our treatment rooms is equipped with cable TV, CD and DVD players, and Sirius Satellite Radio. We are also set up to quickly and easily download movies from the internet. Headsets are available. Would you like to enjoy our entertainment system? Yes No
If yes, which do you prefer? Radio TV CD Movie

**A gentle massage can ease tension and relax you during treatment. Each of our treatment chairs has a soft massage feature from your lower back up through your shoulders. Would you like to try the massage feature? Yes No

**Blankets help keep you warm and comfortable through your visit. Would you like a blanket? Yes No

**Pillows provide extra comfort if you have a sore neck or back. Would you like a pillow? Yes No

**WiFi internet access is available for your use throughout the office. Please feel free to bring your wireless internet device with you to your visits.

**A portable courtesy telephone is always available to you. Please let us know if you need to make a call.

**Is there anything else we can do to make your visit more comfortable?
