Castillo
Family Dentistry

Patient Information

Patient Name _____ Date _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Social Security _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single

Date of Last Exam _____ Name of Examining Dentist _____

Were X-rays taken? ☐ Yes ☐ No

Employer _____ Phone _____

Emergency Contact _____ Phone _____

Relationship _____

Prefered Pharmacy _____

Insurance Information

Policy Holder _____ Date of Birth _____

Social Security _____ Phone _____

Address _____

City/State/Zip _____

Dental Insurance Co. _____

Insurance I.D. _____ Group _____

Continue on other side

Time 9:13 AM | Dr. Sam Castillo, DMD | Date 8/1/2023

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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:_____

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Family Dentistry

Privacy Policies

HIPPA PRIVACY ACT states that no patient information may be shared with any person or office without the written permission of the Patient/Guardian of a minor child.

I understand this policy and have been offered an opportunity to ask questions pertaining to it.

Patient Name:_____

Address:_____

_____

Phone:_____

Patient/Guardian/Parent Signature:

_____

Please list any person or proffesional office that we may discuss your dental treatment with below. **Parents** of children and **spouses** must be listed if you want them to have your consent.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Continue on other side

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Office Policies

I, the undersigned, hereby authorize Dr. Castillo, and/or his designated employees to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Castillo to make a thorough diagnosis of the patient's dental needs. I also authorize the performance of any and all treatment, medication and therapy based on those needs. I further authorize and consent that Dr. Castillo choose and employ such assistance as he deems appropriate. I understand that the use of anesthetic agents embodies certain risks.

I give permission for the staff of Dr Castillo's office to discuss the appointment and treatment information on my voicemail, text message, and/or e-mail.

I understand that the responsibility of payment for dental services provided by this office for myself and/or my dependants is mine, due and payable at the time service are rendered, unless financial arrangements have been made in advance. I understand that my account will be debited $33 for any returned check. I understand that checks that have been returned for Insufficient Funds, if not paid within 10 days of notification, will be turned over to the Magistrate Court or Collection Agency where additional charges will be incurred.

I certify that I am covered by _____(Dental Insurance Provider)_____ and I assign directly to Dr. Castillo all insurance benefits, otherwise payable to me. I understand that I am reposible for the timely payment of my account whether or not my insurance pays. Billing problems, the result of incorrect information provided by me, will incure a $3.00 update/rebilling fee per claim. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

I understand that my insurance carrier may process the actual bill for services. I understand that I am responsible for all costs of dental treatment. I promise to pay payment in full at each appointment. If I do not pay at least a portion of the new balance within 30 days of the monthly billing date, then I understand that my account can be sent to collection agency for further action. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding account.

I understand that if I wish to pre-pay for any services, then those services are considered completed, and no refund will be made if I change my mind regarding the services. A credit will be added to my account for future services instead.

I understand that appointments are considered confirmed at the time they are made. If for any reason I have to cancel my appointment, I understand that I must give atleast a 24 hour notice. If I fail to do so, then I may be subject to a $30 failed appointment fee.

I have read and understand this office's policy regarding payment and appointments.

Patient/Parent Signature: _____ Date: _____