Celeste M. Eckerman, D.D.S.
1702 County Road Suite E
Minden, NV 89423

Today's date:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single Married Other

What do you prefer to be called?	Birth date:	Age:	Sex: ❑ M ❑ F	Social Security Number:

Mailing Address:	Home phone:

City:	State:	Zip:	Cell phone:

Occupation:	Employer:	Work phone:

Email Address:

Whom may we thank for referring you?

Other family members seen here:

Previous Dentist:	Last visit date?

Spouse Information:

Name:

Phone Number:

Social Security Number:

Person responsible for account:	**Same as Above** ☐	Name:

Mailing Address:

Social Security Number:	Phone Number:

Phone Number:

Emergency Contact:

Name:	Phone Number:	Relation:

Please give us a copy of your dental benefit card and driver's license upon check in

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DENTAL HISTORY

Why have you come to the dentist today?			
Are you Currently in pain? Yes No	Your Current Dental Health is: Good Fair Poor	Type of bristles on your tooth brush Hard Medium Soft	Do you floss daily? Yes No
Have you lost any teeth? Yes No Why?	Is your toothbrush: Manual Electric	How long do you use a toothbrush before replacing it?	What other oral products do you use (such as mouthwash):

Do require antibiotics before dental work? Yes No	Do your gums ever bleed? Yes No	Have you ever had periodontal disease? Yes No	Does food get caught between your teeth? Yes No	Are your Teeth Sensitive to heat, cold, or anything else? Yes No

Are you happy with the way your smile looks? Yes No	If not, What would you Change?
Have you had and dental surgeries?	

MEDICAL HISTORY

Do you have a personal Physician? Yes No	Physicians Name:
	Physician's Phone Number:
	Date of Last Visit:

Please List Any Allergies:

Allergy	Reaction	Onset day

Phone Number: 775-782-2799 Fax Number: 775-782-9426

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Have you experienced any of the following?

Y	N	Abnormal Bleeding	Y	N	Frequent or Severe Headaches	Y	N	Radiation Treatment
Y	N	Alcohol Use:	Y	N	Gastric Reflux (GERD), Heartburn	Y	N	Recreational Drug Use
Frequency:			Y	N	Glaucoma	Y	N	Rheumatic Fever
Y	N	Anemia	Y	N	Hay Fever	Y	N	Scarlet Fever
Y	N	Arthritis	Y	N	Heart Murmur/Defect	Y	N	Seizures
Y	N	Artificial Bones / Joints	Y	N	Hepatitis	Y	N	Sinus Problems
Y	N	Artificial Valves	Y	N	High Blood Pressure	Y	N	Sleep Apnea Diagnosis
Y	N	Asthma	Y	N	HIV+ / AIDS	Y	N	Snoring
Y	N	Bleeding Disorder	Y	N	Impaired Cognition(difficulty concentrating or thinking)	Y	N	Steroid Therapy
Y	N	Blood Transfusion	Y	N	Insomnia	Y	N	Stroke
Y	N	Cancer	Y	N	Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	Y	N	Taken: Phen-Phen or Redux
Y	N	Chemotherapy	Y	N	Kidney Problems/Desease	Y	N	Tobacco Use:
Y	N	Colitis	Y	N	Latex allergy	Type:		
Y	N	Congenital Heart Disease	Y	N	Liver Disease	Frequency:		
Y	N	Daytime Sleepiness/Fatigue	Y	N	Low Blood Pressure	Y	N	Tuberculosis (TB)
Y	N	Diabetes	Y	N	Metal Allergy	Y	N	Ulcers
Y	N	Difficulty Breathing	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease
Y	N	Drug Abuse	Y	N	Mood Disorders/Depression			
Y	N	Emphysema	Y	N	Osteoporosis			
Y	N	Fainting Spells	Y	N	Pacemaker			
Y	N	Fever Blisters/Herpes	Y	N	Persistent Cough			

For Women:

Are you taking Birth Control Pills?	Are you Pregnant? If so what week?	Are you nursing?

Please list any past surgery/injuries/ hospitalizations that are not listed above

Year:	Type:

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Please list any medications that you are taking

If you have a written or typed list you may leave this blank

(Please include regularly used over-the-counter medications and nutritional supplements)

Medication Name	Dosage and Frequency	Condition

Communicable Disease control disclaimer

Our Policy and procedure dictated to us by the Nevada Dental Board of Examiners is as follows: if we during treatment find that there are signs of a communicable disease (i.e. Cold or Flu), we have to delay treatment until medical clearance has been obtained from a licensed physician.

Patient's initials: _____ Date: _____

I affirm that the above information is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I understand that I am responsible for all amounts that my insurance doesn't cover. Payment is due in full at the time services are rendered unless prior arrangements have been approved.

Signature: _____ Date: _____

Thank you for filling out these forms completely.
If you have any questions at any time, please ask us.

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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