

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST M MARRIED SINGLE MINOR MALE FEMALE

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

 Yes NoWhom may we thank for referring you to our office?
_____**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

METHOD OF PAYMENT

Responsible party currently has an account with this office

 Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

 I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of 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 accounts.

Eaglesoft Medical History(Copy)

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

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Do you use tobacco? Yes No If yes

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 <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B or C <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No
Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No
Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No
Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Allergies (seasonal) <input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No
Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No
Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Anxiety/Depression <input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No
ADD/ADHD <input type="radio"/> Yes <input type="radio"/> No	Bacterial Endocarditis <input type="radio"/> Yes <input type="radio"/> 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: _____