

**PATIENT REGISTRATION**

ID:

Chart ID:

First Name:

Last Name:

Middle Initial:

Patient Is:  Policy Holder  Responsible Party

Preferred Name:

Responsible Party ( if someone other than the patient )

First Name:

Last Name:

Middle Initial:

Address:

Address 2:

City, State, Zip:

Pager:

Home Phone:

Work Phone:

Ext:

Cellular:

Birth Date:

Soc Sec:

Drivers Lic:

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address:

Address 2:

City:

State / Zip:

Pager:

Home Phone:

Work Phone:

Ext:

Cellular:

Sex:  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date:

Age:

Soc Sec:

Drivers Lic:

E-mail:

I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID:

Pref. Dentist:

Employer ID:

Pref. Pharmacy:

Carrier ID:

Pref. Hyg:

Emerg Contact Name

Referred By:

Married-Spouse Name:

Child-Parent Name

Emerg Contact #

Primary Insurance Information

Name of Insured:

Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Ins. Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

Rem. Benefits:

Rem. Deduct:

Secondary Insurance Information

Name of Insured:

Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Ins. Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

Rem. Benefits:

Rem. Deduct:

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

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

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

Do you use controlled substances? Yes No If yes
Other? If yes

Do you have, or have you had, any of the following?

Table with 3 columns of medical conditions and Yes/No columns. Includes: AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problems, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Yellow Jaundice, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease.

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: