TIME 10:40 AM DATE 6/18/2019

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

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:

Section 3

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 For Scottsburg

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, c

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?

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	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 / COPD	◯ 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
Allergies	◯ Yes ◯ No	Heart Burn	◯ Yes ◯ No		

Have you had any serious illness not listed:	◯ Yes ◯ No	If yes

Do you

Grind your teeth?	◯ Yes ◯ No	Have bledding gums:	◯ Yes ◯ No	Loose, chipped or shifting teeth?	◯ Yes ◯ No
Bad Breath:	◯ Yes ◯ No	Dentures? Upper/Lower	◯ Yes ◯ No	Partials: Upper/Lower	◯ Yes ◯ No
Braces: Upper/Lower	◯ Yes ◯ No				

Are your teeth sensitive to hot, cold, sweet biting?	◯ Yes ◯ No	If yes

Date of your last cleaning? _____ Where? _____

Comments? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my (or patient's) health. It is my respons

X _____ Date: _____

Signature of Patient, Parent or Guardian

SCOTTSBURG FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(PLEASE PRINT NAME)

_____
(PLEASE SIGN YOUR NAME)

_____
(DATE)

YOU MAY RELEASE INFORMATION FOR THIS PATIENT TO:

_____ _____
(NAME) (RELATIONSHIP TO PATIENT)

_____ _____
(NAME) (RELATIONSHIP TO PATIENT)

_____ _____
(NAME) (RELATIONSHIP TO PATIENT)

_____ _____
(NAME) (RELATIONSHIP TO PATIENT)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please specify below)

_____

_____

COVID-19
WAIVER OF LIABILITY AND RELEASE AGREEMENT
(Patient)

THIS IS AN IMPORTANT DOCUMENT. YOU MUST READ IT BEFORE SIGNING. IN SIGNING THIS DOCUMENT, YOU ARE WAIVING IMPORTANT LEGAL RIGHTS.

In consideration for the opportunity to receive dental treatment from _____ (the "Practice") and the professionals retained thereby, at the Practice's office located at _____ (the "Practice's Office"), and for other good and valuable consideration, I, _____ (the "Patient"), hereby state and agree as follows:

1. I recognize that my obtaining dental treatment at the Practice's Office presents risks to me, including the risk of coming in contact with the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or my contracting coronavirus disease (COVID-19), including my risk of severe illness and/or death.

2. I hereby release, acquit, waive all claims against, and forever discharge the Practice and its owners, successors, assigns, affiliates, officers, directors, administrators, representatives, principals, agents, servants, employees, independent contractors, insurers, and attorneys (collectively with the Practice, the "Indemnified Persons"), of and from any and all claims, charges, demands, promises, acts, agreements, costs, damages, debts, obligations, actions, causes of action (including but not limited to all avoidance actions of any type), suits in equity, expenses, executions, judgments, levies, liabilities, losses, and attorneys' fees, of whatever kind or nature, whether legal or equitable, liquidated or unliquidated, fixed or contingent, direct or indirect, suspected or unsuspected, accrued or unaccrued, known or unknown, present or future, asserted or unasserted, based upon, arising out of, appertaining to, or in connection with my exposure to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or my contracting coronavirus disease (COVID-19) as a result of or in connection with my entry into the Practice's Office, receiving dental treatment at the Practice's Office, or coming in contact with any Indemnified Person at or near the Practice's Office, and all related costs, expenses, illness, or death I may suffer as a result.

3. The releases set forth and otherwise referenced herein shall be interpreted as broadly as possible and shall be completely binding and enforceable at law. I acknowledge that the releases and waivers provided for herein include all claims and/or costs, including but not limited to those they do not know or suspect to exist, and hereby waive all rights which may exist with regard to such claims and/or costs. I expressly waive the provisions of any federal, state, and local statute or regulation limiting release of unknown claims, including any statutory language stating as following: "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY, AND ANY SIMILAR LAW."

4. For Parents/Guardians: In addition to the foregoing, we/I further waive all claims against (to the same extent described in Paragraph 2), and agree to hold harmless and indemnify, the Indemnified Persons and each of them, for any illness, death, costs, expenses, or other loss sustained by the Patient which results in any way from the Patient's entry into the Practice's Office, receiving dental treatment at the Practice's Office, or coming in contact with any Indemnified Person at or near the Practice's Office.

5. I agree that I have had the opportunity to consult with an attorney prior to executing this Waiver of Liability and Release Agreement, that I voluntarily have signed the same and that I have read and understand this Waiver of Liability and Release Agreement. **I FULLY UNDERSTAND THAT, BY SIGNING THIS WAIVER OF LIABILITY AND RELEASE AGREEMENT, I AM WAIVING IMPORTANT LEGAL RIGHTS.**

IN WITNESS WHEREOF, I have signed this Waiver of Liability and Release Agreement this ____ day of _____, 2020.

Witness:	**Patient:**
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____

Parent's/Guardian's Signature (if Patient is under 18): The undersigned is a parent(s) or legal guardian(s) of the Patient and hereby consents to the foregoing Waiver of Liability and agrees (1) on behalf of the Patient for Patient to be bound by the provisions hereof and (2) on behalf of himself or herself and each other parent or guardian of the Patient, that all of the terms hereof, including all liability waived hereby, equally apply to and they are subject to each of them.

Signature: _____

Print Name: _____

Date: _____