Bloomington Family Dental

Ryan E. Kloboves, DDS Robert Shirley, DDS

Release of Information

I, _____, give my permission to the staff of Bloomington Family Dental to discuss completed and proposed treatment with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Signing this form also grants permission for dental records and x-rays to be shared with specialists and other dental practices as needed for patient's care.

_____
Patient or Responsible Party Signature

_____
Date

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Patient Registration

Date: _____

Patient Information:

First Name: _____Last Name: _____Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____Ext: _____ E-mail: _____

Birth date: _____ SSN: _____Employer: _____

Sex: ___Male ___ Female Marital Status: Single ___ Married ___ Divorced ___ Separated___ Widowed___

Is there anything you would like to change about your smile?:_____

Previous Dentist: _____ Reason for leaving:_____

Preferred Pharmacy: _____ Primary Physician : _____

Referred By: Patient Name _____ Drive-by ____ Yellow Pages ____ 1-800-Dentist ____

Direct Mailer ____ Google Ad ____ Facebook Ad ____ Radio _____ Other _____

Patient is Policy Holder/Responsible Party: Yes _____ No _____

Responsible Party or Policy Holder Information: (If someone other than the patient)

Responsible Party Name: _____Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____Ext: _____ E-mail: _____

Birth date: _____ SSN: _____-_____-_____ Employer: _____

Emergency Contact Information:

Name:_____ Relationship:_____ Phone #:_____

Time 3:34 PM | Bloomington Family Dental | Date 10/21/2015

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

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

Other?	☐	If yes
Do you use controlled substances?	Yes No	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	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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Financial Statement

We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. Also, we understand the financial limitations that may influence your choice of care.

We work with most insurance companies and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. As a courtesy, we complete and file all claims to your insurance carrier and we're available to answer any questions you may have.

Please remember, however, that you are responsible for the portion of your treatment not covered by your insurance. We do ask that you pay the estimated portion of your services at the time of treatment. If you qualify, we offer Care Credit which can assist you in interest free monthly payments. We also accept all major credit cards.

Should your account become delinquent, we will place the account with a collection agency, and you will be responsible for fees equaling 20% of any unpaid balance placed for collection.

We hope that you find this information useful. Rest assured that we are here to help make quality dental care obtainable for all. We look forward to working with you to achieve excellent dental health.

_____

Patient or Responsible Party Signature

_____

Date