

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____

Patient Information:

Address: _____
City, State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: Female Male Marital Status: Married Single Divorced Separated Widowed
Birth date: _____ Social Security #: _____ (For insurance purposes)
E-mail: _____

Patient Information (section 2):

Employment Status: Full Time Part Time Self Employed Retired Unemployed
Referred By: _____ Reason for visit: _____
Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Primary DENTAL Insurance Company: _____

Name of Insured: _____ Relationship to Insured: Self Spouse Child other
Subscriber ID #: _____ Group #: _____
Insured Social Security #: _____ Insured Birth date: _____
Employer: _____
Present Position: _____

Secondary DENTAL Insurance Company: _____

Name of Insured: _____ Relationship to Insured: Self Spouse Child other
Subscriber ID #: _____ Group #: _____
Insured Social Security #: _____ Insured Birth date: _____
Employer: _____ Insurance Company: _____
Present Position: _____

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
- 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

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

- 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 <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 |
| Hepatitis A <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 B or C <input type="radio"/> Yes <input type="radio"/> No |
| Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No | Anemia <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <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 | Shingles <input type="radio"/> Yes <input type="radio"/> No | Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <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 |
| Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <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 |
| Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <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 | Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No |
| Ulcers <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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: _____