Today's Date _____ Office Staff Initial_____

Patient Registration Form

First Name _____ Last Name _____ Middle Initial _____ Preferred Name _____

Birth Date _____ /_____ /_____ Sex ☐ Male ☐ Female Social Security # _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Email _____ I would like to receive correspondence via ☐ Text Message ☐ Email

Home Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

DENTAL CLINIC OR DENTIST WHO REFERRED YOU _____ **Phone** (_____) _____

Emergency Contact Name _____ Relation _____ Emergency Phone (_____) _____

Family Physician Name _____ Family Physician Phone (_____) _____

Dental Insurance ☐ **Yes** ☐ **No** **Self Pay** ☐ **Cash** ☐ **Care Credit** ☐ **Credit Card** **(Visa/Mastercard)**

Primary Dental Insurance

Subscriber Name _____

Relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Birth Date _____ /_____ /_____

Insurance Company _____ Group # _____

Subscriber Policy ID Number _____

Subscriber Social Security Number _____

Secondary Dental Insurance

Subscriber Name _____

Relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Birth Date _____ /_____ /_____

Insurance Company _____ Group # _____

Subscriber Policy ID Number _____

Subscriber Social Security Number _____

Insurance Policy

Our office at no time guarantees what or how the patient's dental insurance will or will not process a claim. Each and every claim is subject to review by the insurance company before the claim is processed. The dental insurance carrier never guarantees payment of any service. ***"Verification of benefits does not guarantee payment. Payment will only be made after claim is submitted."*** We can only assist the patient in estimating their portion of the cost of treatment based on the information we have gathered from the insurance company website, fax back, or representative. I understand that the office is not responsible for how a patient's dental insurance company handles the claims or for what benefits they pay on a claim. I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Patient's Signature _____ Date _____

Financial Agreement

I, acknowledge that payment is due at the time of treatment, unless other arrangements are made. I accept full financial responsibility for all charges.

Patient's Signature _____ Date _____

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 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
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:_____