PATIENT REGISTRATION

DATE	LAST NAME	FIRST NAME	M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE	
CIRCLE: MALE FEMALE	CIRCLE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED		
AGE	BIRTHDATE	SOCIAL SECURTY #	
EMAIL ADDRESS			
WHOM MAY WE THANK FOR INVITING YOU TO OUR PRACTICE?			

IF PATIENT IS YOUR CHILD:

LAST NAME	FIRST NAME	M.I.
ADDRESS		
CITY	STATE	ZIP
CONTACT NAME AND NUMBER		
BIRTHDATE AGE		CIRCLE : MALE OR FEMALE
SCHOOL		GRADE
PERSON FINANCIALLY RESPONSIBLE FOR CHILD		

- ☐ FULL TIME RESIDENT
- ☐ SEASONAL RESIDENT

EMERGENCY INFORMATION

PERSON TO CONTACT FOR EMERGENCY	PHONE NUMBER

INSURANCE INFORMATION

INSURANCE COMPANY	GROUP NUMBER
EMPLOYER NAME	
INSURED'S NAME	RELATIONSHIP TO PATIENT
INSURED'S DATE OF BIRTH	INSURED'S SS # OR MEMBER ID#

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, 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	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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 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 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:_____

Broken Appointments

_____Your appointment is reserved specifically for you! Our office requires a reschedule or cancellation notice of **48 business hours** (*ex. Monday appointments must be cancelled by Thursday, Tuesday appointments must be cancelled by Friday, etc.*). If an appropriate 48-business hour notice is **NOT** given, or you **NO SHOW** for your appointment, **a minimum $50 fee per scheduled hour** will be charged to your account (*ex. $50 for a 30-60 min. appointment, $100 for 120 min. appointment, etc.*).

Insurance and Financial Payments

_____As a courtesy to you, we are happy to file claims on your behalf. Please understand that our relationship is with you and not with your dental insurance carrier. Your insurance coverage depends on the quality of the plan purchased by your employer. All insurance plans are different. Insurance companies do not give us exact reimbursement amounts only **estimated amounts**.

_____Any balances that are unpaid by your dental insurance carrier **within 90 (ninety) days of your appointment** will be solely your financial responsibility. Please feel free to contact your insurance carrier directly to discuss your claim payment status. Payments for all dental and/or hygiene services, including your estimated insurance co-pays, are to be collected at the time of service unless other arrangements with us have been made.

Electronic Communication

_____Now that you are our valued patient, you have been automatically enrolled in our state of the art appointment confirmation and communication system. This system ensures that you receive texts and e-mails regarding important information from our office without interrupting your busy day. If you prefer a telephone call from us instead of being automatically enrolled in our electronic communication system, please indicate below:

- ☐ I accept being automatically enrolled in the electronic communication system.
- ☐ I decline being automatically enrolled in the electronic communication system.

HIPAA Notice of Privacy

- ☐ I acknowledge that, if requested, I will received a copy of the HIPAA Notice of Privacy from Indigo Dental. You may discuss my dental treatment with the following person(s):

  _____

- ☐ Please do not discuss my treatment with anyone.

I have read, accept and understand the above Indigo Dental office policies. I further authorize Indigo Dental to release any information concerning my dental treatment to my insurance carrier(s).

Print Name: _____

Patient Signature: _____Date: _____

Witness Signature: _____ Date: _____