PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:

☐ Responsible Party

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

Spouses Name:

Where patient lives:

Pets Name:

Favorite:

Children:

Sports:

Other:

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: .00 Rem. Deduct: .00

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: .00 Rem. Deduct: .00

Time 11:29 AM

Henderson Family Dentistry

Eaglesoft Medical History

Date 2/29/2016

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.

Question			
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?

Condition			Condition			Condition			Condition		
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:__________

Henderson Family Dentistry

1910 State Hwy 43 East, Henderson, TX 75652

Name: ______________________________

You may discuss my dental treatment with: ______________________________

You may discuss my finances and account information with: ____________________

You may leave a personal dental message on my home/cellular voicemail. Y / N

You may leave a personal dental message with my spouse. Y / N

Henderson Family Dentistry

1910 State Hwy 43 East, Henderson, TX 75652

Notice to the Parents of Legal Guardians of a Minor

If your child is a minor you **MUST** be present at your child's **initial visit** to sign the parental consent form below and provide your child's social security number. The consent form you sign gives the physicians and staff of Henderson Family Dentistry permission to treat your child. Without a signed consent form, we cannot legally treat a minor child. **If you are not the parent,** but are the **Legal Guardian,** you will need to provide legal documentation that you are the legal guardian. This information will be kept in the child's file.

CONSENT TO TREAT MINOR

I authorize Henderson Family Dentistry to treat and provide and healthcare services to my child that the provider deem necessary for treatment and/or diagnosis. I also understand, in the course of treatment, photographs may be taken for clinical or educational purposes.

UNACCOMPANIED MINORS

I grant permission to treat and provide any healthcare services to my child that the providers deems necessary for treatment if my child arrives at the office unaccompanied. Initials________

MINOR ACCOMPANIED BY OTHERS

If I am unable to accompany y my child to the appointment, the below listed individuals have my permission to accompany my child. This agreement is required in order for the unaccompanied child to be seen and treated. I also, grant my permission for the below listed person(s) to sign any documentation that Henderson Family Dentistry deems necessary for treatment. Initials________

I further acknowledge this consent will remain in effect until either I revoke, in writing and delivered to you, or the minor reaches the age of 18 years.

______________________________ ______________________________ ____/____/____

Print Guardian Name **Guardian Signature** **Date**

____

Patient Name

OTHER INDIVIDUALS ALLOWED TO ACCOMPANY MY CHILD

Name ______________________________ Relationship to Patient________________
Name ______________________________ Relationship to Patient________________
Name ______________________________ Relationship to Patient________________
Name ______________________________ Relationship to Patient________________

Pre-Payment Policy:

Pre-payment is required for all prescribed/accepted dental treatment. Patients will be expected to pay their portion at check- in the day of appointment, before services are rendered. An estimated treatment plan will be given to all patients for future treatment needs before their appointments are made so you will be aware of the amounts due the day of your appointments. Please be aware that there may be instances that treatment needs may change during your appointment, any additional fee will be explained to you at that time and will be due at check-out.

We offer CareCredit to our patients to assist them in taking care of their dental needs. You can apply for CareCredit at our office, online at caredcredit.com or by calling 800-365-8295. This can be used at your appointments to pay your out of pocket cost. Please request to speak to our Office Manager to apply here in our office for an instant approval.

______________________________ ______________

Responsible Party Signature Date