

REGISTRATION FORM

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Birthdate: _____ SSN: _____
Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Address: _____
City, State, Zip: _____ Cell Phone: _____ Home Phone: _____
Email: _____

Responsible Party: (if other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Birthdate: _____ SSN: _____
Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Address: _____
City, State, Zip: _____ Cell Phone: _____ Home Phone: _____
Email: _____

Insurance Information:

Primary:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child
Name of Insured: _____ Birthdate: _____ SSN: _____
Employer: _____ Insurance Company: _____
Subscriber ID #: _____ Group #: _____

Secondary:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child
Name of Insured: _____ Birthdate: _____ SSN: _____
Employer: _____ Insurance Company: _____
Subscriber ID #: _____ Group #: _____

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Number: _____
Pharmacy Address: _____

Appt. Reminder Preference:

☐ Email ☐ Text Message ☐ Phone Call

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		
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: _____

Financial & Payment Policy
For The Office of Premier Dental / Esthetic Dental Implants Studio

We are proud to be a team whose primary mission is to deliver the most up to date and comprehensive dental care services today. Following diagnosis, the doctor will advise you of our plan for treatment.

Payment for today's visit and your future visits are due at the time of treatment. If you have dental insurance, your responsibility will be estimated on your treatment plan. In order to assist you with your dental care investment, we are providing the following payment options:

Payment Options:

**Cash or Check, Visa, MasterCard, American Express, Discover
Care Credit* or Cherry***

*Care Credit and Cherry offer a separate line of credit to cover your entire dental health needs

*Approval to establish a credit line usually takes less than 10 minutes

*Care Credit and Cherry have interest free options (if approved)

*There are no annual or membership fees

Insurance:

We will gladly process your insurance claims for you. **However, it is your responsibility to know your insurance terms** (Network Status, Annual Max, Coverage and History, etc.).

Insurance and patient portions are **estimates** provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.

The estimated amount covered by your insurance is due at the time of treatment and may be paid by one of the options listed above.

Appointment Policy

So that we may provide you with the timeliest care possible, please schedule your appointment for a time you will be able to keep.

There will be **a charge for cancelled or no show visits** if we have not been notified at least 48 hours in advance.

Thank you for your cooperation.

Signature of Patient/Responsible Party

Date

Premier Dental / Esthetic Dental Implants Studio

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgment ****

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Print Name (if patient is a minor print parent/guardian name)

Signature

Date

I authorize Premier Dental to release my medical information automatically to:

Names and Relationships:

Emergency Contact:

Name: _____ Phone Number: _____

Relationship: _____