Patient Registration
Dental Health Center 208-356-9262

PATIENT INFORMATION

Name: ______________________ Birthdate: ___________ Social Security #: ___________

Address: __________________ City and State: _____________ Zip Code: ______________

Phone Number: _______________ Employer: _________________ Work Phone: _________

Gender: ________ Email: ______________________ Marital Status: ________________

How did you hear about us? ____

SPOUSE INFORMATION

Name: ______________________ Birthdate: ___________ Phone Number: ___________

Employer: ____

INSURANCE

Dental Insurance: ______________________ Policy Holder: __________________________

Policy Holder Address: _________________ City and State: ____________ Zip Code: _______

Phone: ______________ Policy Holder Birthdate: ___________ Employer: ________________

Insurance ID #: __________________________ Group #: ____________________________

Secondary Insurance: ______________________ Policy Holder: _______________________

Policy Holder Address: _________________ City and State: ____________ Zip Code: _______

Phone: ______________ Policy Holder Birthdate: ___________ Employer: ________________

Insurance ID #: __________________________ Group #: ____________________________

Medical Insurance: ______________________ Policy Holder: _________________________

Policy Holder Address: _________________ City and State: ____________ Zip Code: _______

Phone: ______________ Policy Holder Birthdate: ___________ Employer: ________________

Insurance ID #: __________________________ Group #: ____________________________

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

Question	Answer	
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?

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 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:__________

Patient Authorizations

_________ I authorize insurance payments be made directly to Dental Health Center. I understand I am responsible for any unpaid balance.

_________ I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPPA).

_________ I hereby authorize the Dental Health Center to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. This information on this page and the medical history are correct to the best of my knowledge

Authorization & Financial Agreement

As a courtesy, we will file your claim to your insurance company according to the information you give us. We are not responsible for claims that are denied due to incorrect insurance information provided to us. It is your responsibility as a patient to notify us of any changes or additional insurance coverage.
Some insurances have a 30 days timely filing period so if we have not been provided with the necessary information before the 30 days have passed you may be responsible for the full amount of your treatment. We recommend that you follow up with our office if you have not received an Explanation of Benefits from your insurance and/or a statement from our office.
We are happy to assist you if you have any questions concerning your coverage or benefits to the best of our ability.

I understand that I am responsible for all costs of dental treatment regardless of insurance coverage or insurance payments. I also authorize payment directly to the Dental Health Center of any insurance benefits.

I understand that I will be charged interest at a rate of twenty-one percent (21%) per year, reasonable attorney fees and court costs, and a fee of thirty-five percent (35%) of the unpaid balance in the event my account is turned to a third part collection agency.

SIGNATURE OF RESPONSIBLE PARTY

X____

☐Adult Patient ☐Father (or Husband) ☐Mother (or Wife) ☐Guardian

Notice of Privacy Practice- Acknowledgement

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below on the next page I acknowledge receipt of the Notice of Privacy Practices.

Patient Authorizations

Authorization for Appointment Confirmation and Office Communications

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, messages left with family members, voicemail messages, text messages, and emails. Usually within these reminders a certain amount of specific and detailed information, consisting of the patients' appointment time and date, or need for an appointment may be included.

I give my permission to receive reminders in the following:

Text: ______________________________

Email: ______________________________

Phone 1: ______________________________

Phone 2: ______________________________

Authorization to Discuss Treatment & Financial Information

By my signature below, I authorize Dental Health Center and staff to discuss treatment and financial information with the people named below for the duration of my treatment with their office.

Name: _________________________ Relationship to Patient: _______________Cell Phone #: _______________

Name: _________________________ Relationship to Patient: _______________Cell Phone #: _______________

☐ I do not authorize Dental Health Center to discuss treatment and financial information with anyone other than myself.

Patient's Signature: ____ **Date**: _______________