TIME 08:57 AM DATE 10/11/201

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

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

Emergency Contact

Emergency Phone

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: Rem. Deduct:

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: Rem. Deduct:

Time 8:55 AM | Doran J.Riehl D.D.S.,P.S. | Date 10/11/2016

Eaglesoft Medical History Revision 9-2-15

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

Are you under a physician's care now?	Yes No	If yes
Are you taking any medications?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Have you been hospitalized or had surgery within the last 2 years?	Yes No	If yes
Have you had any major operations that affect your current health?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Are you vision or hearing impaired?	Yes No	If yes
Do you use tobacco?	Yes No	
If you use tobacco are you ready to quit?	Yes No	If yes

Are you allergic to any of the following?

Asprin	Codeine	Penicillin	Sulfa Drugs
Local Anesthetic	Latex	Acrylic	Metal

Other Allergies? If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Conditions

Do you have any of the following conditions that would affect receiving dental treatment?

Back Problems	Yes No
Breathing Problems	Yes No
Fear of Dentistry	Yes No
Head Injury	Yes No
Neck Problems	Yes No
Jaw Conditions	Yes No
Sensitive Teeth	Yes No
Urinary Incontinence	Yes No
Vertigo	Yes No

Do you have, or have you had, any of the following?

Acid Reflux/Heartburn Yes No	Cold Sores/Fever Blisters Yes No	Hemophilia Yes No	Radiation Treatment Yes No
AIDS/HIV Positive Yes No	Cortisone Medication Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Alzheimer's/Dementia Yes No	Diabetes Yes No	Hepatitis B or C Yes No	Recovering Alcoholic Yes No
Anaphylaxis Yes No	Dry Mouth Yes No	Herpes Yes No	Renal Dialysis Yes No
Anemia Yes No	Drug Addiction Yes No	High Cholesterol Yes No	Rheumatic Fever Yes No
Anorexia/Bulimia Yes No	Emphysema/COPD Yes No	High/Low Blood Pressure Yes No	Seasonal Allergies Yes No
Arthritis Yes No	Epilepsy or Seizures Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hypoglycemia Yes No	Sinus Trouble Yes No
Artificial Joint Yes No	Fainting Spells/Dizziness Yes No	Kidney Conditions Yes No	Sleep Disorder Yes No
Asthma Yes No	Frequent Cough Yes No	Leukemia Yes No	Special Needs Yes No
Autism Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stomach/Intestinal Disease Yes No
Autoimmune Disease Yes No	Glaucoma Yes No	Lung Disease Yes No	Stroke Yes No
Breathing Problems Yes No	Heart Attack/Failure Yes No	Memory Loss Yes No	Thyroid Disease Yes No
Bruise Easily Yes No	Heart Disease/Condition Yes No	Mental Health Care Yes No	Tonsillitis Yes No
Cancer Yes No	Heart Murmur Yes No	Mitral Valve Prolapse Yes No	Tuberculosis Yes No
Cardiac Surgery Yes No	Heart Pacemaker/ICD Yes No	Osteoporosis Yes No	Tumors or Growths Yes No
Chemotherapy Yes No	Heartbeat Irregular Yes No	Pain in Jaw Joint Yes No	Ulcers Yes No
Chest Pain/Angina Yes No			

Have you ever had any serious illness not listed Yes No If yes

Comment

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:_____