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

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: ______

Feels Like Family Dentistry

Eaglesoft Medical History 5.25.23 Edit

Patient Name: Birth Date: Date Created:

Question	Answer	If yes
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?	◯ 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 bisphosphonate medications?	◯ Yes ◯ No	If yes
Are you on a special diet? What diet?	◯ Yes ◯ No	If yes
Do you use tobacco? What type?	◯ Yes ◯ No	If yes
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	Answer	Condition	Answer	Condition	Answer	Condition	Answer
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 B or C	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ 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	Heart/ Artificial 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	Heart/ 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
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
Heart/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	Pain in Jaw Joints	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Heart/ Congenital Disorder	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No

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

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:__________

Medications/Prescriptions

Medication Name	Dosage	Reason for Use

Acknowledgement of Receipt of HIPAA Policies and Procedures

You may refuse to sign this acknowledgment

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures. I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Patients Name(s): ____

Guardian's Name: ____

Signature:__________________________________ Date _______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

o Individual refused to sign ___________

o Communication barriers prohibited obtaining the acknowledgement ____________

o An emergency situation prevented us from obtaining acknowledgement__________

Feels Like Family Dentistry

Dental Health History

Patient Name: Birth Date: Date Created:

How often do you brush? Comment

How often do you floss? Comment

Please Check YES or NO

Question	Yes	No
Are you apprehensive about dental treatment?	Yes	No
Do you wear dentures?	Yes	No
Do you have difficulty chewing your food?	Yes	No
Do you avoid brushing any part of your mouth?	Yes	No
Do your gums bleed when you floss?	Yes	No
Have you ever noticed slow healing sores?	Yes	No
Do you take flouride supplements?	Yes	No
Do you prefer to save your teeth?	Yes	No
Does your jaw make noise so that it bothers you/others?	Yes	No
Do your jaws ever feel tired?	Yes	No
Does it hurt when you chew or open wide to take a bite?	Yes	No
Do you have any jaw symptoms or headache upon waking in the morning?	Yes	No
Do you find jaw pain or discomfort extremely frustrating or depressing?	Yes	No
Do you have temporomandibular (jaw) disorder (TMD)?	Yes	No
Are you unable to open your mouth as far as you want?	Yes	No
Have you had a blow to the jaw (trauma)?	Yes	No
Are you a habitual pipe smoker?	Yes	No
Have you had problems w/ previous treatment?	Yes	No
Does food catch between your teeth?	Yes	No
Do you chew on only one side of your mouth?	Yes	No
Do your gums bleed easily?	Yes	No
Do your gums feel swollen or tender?	Yes	No
Are your teeth sensitive?	Yes	No
Are you dissatisfied with the appearance of your teeth?	Yes	No
Do you want complete dental care?	Yes	No
Do you clench or grind your jaws frequently?	Yes	No
Does your jaw get stuck so that you can't open freely?	Yes	No
Do you have earaches or pain in front of the ears?	Yes	No
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	Yes	No
Do you take medications for pain or discomfort? (IE: pain relievers, muscle relaxers, antidepressents)	Yes	No
Do you have pain in the face, cheeks, jaws, joint, throat, or temples?	Yes	No
Are you aware of an uncomfortable bite?	Yes	No
Are you a habitual gum chewer?	Yes	No
Do you gag easily?	Yes	No

Do you feel twinges of pain when your teeth come in contact with:

Item	Yes	No
Hot foods/liquids?	Yes	No
Cold foods/liquids?	Yes	No
Sours?	Yes	No
Sweets?	Yes	No

Signature of Patient, Parent or Guardian:

X

Date:__________

INSURANCE AGREEMENT:

I certify that the insurance information I have provided is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and me. **I understand that an estimated portion is due at time of service** and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that any amount not covered by my insurance company becomes my responsibility. If your dental plan has not paid your account in full within 45 days, the balance must be paid at once when you receive your statement.

______________________________________ ___________________________

Signature of Responsible Party Date

APPOINTMENT AGREEMENT:

When you schedule an appointment you are reserving time in our office. We will send email and text reminders to remind you of upcoming appointments and to allow for confirmation if you plan to attend. **You must confirm your appointment forty-eight hours prior to your appointment or it will be deleted**. We ask that you give our office twenty-four hours' notice for any changes or cancelation of your appointment. **A fee of $25.00 per appointment hour will incur without a twenty-four hours' notice.**

______________________________________ ___________________________

Signature of Patient or Guardian Date

CONSENT FOR TREATMENT:

I agree to have the staff of Feels Like Family Dentistry take all diagnostic tests deemed necessary to make a diagnosis. I agree to have all mutually agreed upon treatment performed by the doctor and her assistants. I agree to the use of anesthetics and other medications deemed necessary acknowledging that using anesthetic agents have certain risks. I give consent for Feels Like Family Dentistry and staff to use any oral, written, or electronic health records that are specifically identified as mine in order to carry out treatment, payment and health care operations. I understand that the minimum amount of information necessary to provide proper care will be used and that a notice identifying the protection of my personal health information is available.

______________________________________ ___________________________

Signature of Patient or Guardian Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization form permits Feels Like Family Dentistry to use or disclose the protected health information listed in the description section below for the following patient:

Patient Name: ______________________________ Birth Date: ______________

Address: ____

City/State/Zip: ____

The following is the person or entity to receive the information:

Recipient's Name: ______________________________ Birth Date: ______________

Address: ____

City/State/Zip: ____

Description of information to be used or disclosed: APPOINTMENT, PROCEDURE, AND/OR BILLING INFO

Purpose of use or disclosure: TO MEET DISCLOSURE REQUESTED OF PATIENT

Expiration date or event: UNTIL REVOKED BY PATIENT

Rights of the Patient

I understand that I have the right to refuse to sign this authorization at any time by sending a written notification to the address listed at the top of the form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____ ______________

Signature of Patient or Personal Representative (as defined by HIPAA) Date

Attach necessary documentation of description of Personal Representative's authority.

Office use only:

____ ______________

Receiving employee Date received