Welcome

Please fill out this form completely, it is important to your care.

ABOUT YOU

Today's Date: _____ ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name: _____ (LAST / FIRST / MI) ☐ M ☐ F Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____ (CITY / STATE / ZIP)

Hm #: (_____) _____ Cell #: (_____) _____ Wk #: (_____) _____ DL #: _____

E-Mail Address: _____ When are the best times to reach you? _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ (CITY / STATE / ZIP)

General Doctor: _____ Previous or Present (Please circle) Date of last visit: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____ Wk #: (_____) _____

Hm #: (_____) _____ Address: _____ (CITY / STATE / ZIP)

SPOUSE INFORMATION

His/Her Name: _____ Birthdate: ___/___/___ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Person Responsible for Account, if other than yourself

Name: _____ Relation: _____ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Hm #: (_____) _____ Billing Address: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____ Employer's Address: _____ (CITY / STATE / ZIP)

Secondary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____ Employer's Address: _____ (CITY / STATE / ZIP)

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:_____