Patient Registration
(Adult)

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

Pref. Dentist: ____________

Pref. Pharmacy: ____________

Pref. Hyg: ____________

Section 3

Patient Employer ____________

Spouse Name ____________

Spouse Employer ____________

Patient Job Title ____________

Spouse Job Title ____________

Physician ____________

Primary Dental 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 Dental 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: ____________

Jennifer A Kennedy, DDS, LLC

Eaglesoft Medical History-Adult

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.

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized?	Yes No	If yes
Have you ever had a major operation?	Yes No	If yes
Have you ever had a head, neck, or back injury?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	If yes
Do you have a history of Oral Surgery?	Yes No	If yes
Do you have a history of Orthodontics?	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
- Metal
- Penicillin
- Latex
- Codeine
- Sulfa Drugs
- Acrylic
- Local Anesthetics

Question	Answer	
Other?		If yes
Do you use controlled substances?	Yes No	If yes

Emergency Information:

Please list below names, relationships and contact phone numbers of person(s) to notify in case of an emergency:

Please state below the name and phone number of your Physician:

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Alzheimer's Disease	Yes No	Anaphylaxis	Yes No	Anemia	Yes No
Angina	Yes No	Arthritis/Gout	Yes No	Artificial Heart Valve	Yes No	Artificial Joint	Yes No
Asthma	Yes No	Blood Disease	Yes No	Cancer	Yes No	Chemotherapy	Yes No
Cold Sores/Fever Blisters	Yes No	Congenital Heart Disorder	Yes No	Cortisone or Steroids	Yes No	Diabetes	Yes No
Drug Addiciton	Yes No	Emphysema/COPD	Yes No	Epilepsy/Seizures	Yes No	Fainting/Dizziness	Yes No
Frequent Headaches	Yes No	Glaucoma	Yes No	Heart Attack/Failure	Yes No	Heart Pacemaker	Yes No
Hemophilia	Yes No	Hepatitis A,B,C	Yes No	Herpes	Yes No	High/Low Blood Pressure	Yes No
High Cholesterol	Yes No	Hypoglycemia	Yes No	Kidney Problems	Yes No	Liver Disease	Yes No
Lung Disease	Yes No	Osteoporosis	Yes No	Pain in Jaw Joints	Yes No	Thyroid/Parathyroid Problems	Yes No
Psychiatric Care	Yes No	Radiation Treatments	Yes No	Renal Dialysis	Yes No	Sleep Breathing Disorder	Yes No
Sinus Trouble	Yes No	Stomach/ Intestinal Disease	Yes No	Stroke	Yes No	Temporal Arteritis	Yes No
Ulcers	Yes No	Sexually Transmitted Diseases	Yes No				

Question	Answer	
Have you had any serious illness not listed above?	Yes No	If yes

Comments

Medications

Are you any taking any medications, pills, or drugs? ◯ Yes ◯ No

Please list below:
Name of Medication, Dose, Frequency, and Reason for taking.

Dental History

When did you last see a dentist?

Name of dentist:

Please list any unfavorable experiences in a dental office:

Please describe any recent dental discomfort:

Who may we thank for referring you to this office?

How would you improve the appearance of your teeth?

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:

X

Date:___________