Eaglesoft Medical History2015

Patient Name: Birth Date: Date Created:

Name

NAME:_____

Birth Date:_____

Patient Information

Address, City, State,Zip_____

Home Phone:_____Cell Phone:_____

____Male____Female Soc Sec #_____ Family Doctor:_____

Email Address:_____

Employer: _____Employer Phone #:_____

Dental Ins:_____ Group # _____ ID#_____

Emergency Contact:_____Phone #_____ Relationship:_____

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

Are you under a physician's care now, other than annual check-ups?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation within the past 5 years?	◯ 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 use tobacco?	◯ Yes ◯ No	

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

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

Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blister	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No

Have you ever had any serious illness not listed

consent

I GIVE MY PERMISSION FOR ACCESS TO MY RECORDS FOR THE FOLLOWING PEOPLE:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements at time of service.
If we file your insurance, you are expected to pay the difference in your company's estimated payment and our charges when services are rendered.
YOU ARE RESPONSIBLE TO KNOW YOUR INSURANCE BENEFITS AND COVERAGE.
If your insurance company has not paid in 60 days, you will be responsible for paying this account in full. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates. It is agreed that payments will not be withheld because of insurance coverage or the pendency of claims theron, and all proceeds of insurance are assigned to this officewhere applicable. If your account becomes delinquent and is turned over to our attorney or a collection agency, you will be responsible for any fees incurred in the collectionof the account.
NOTE: There is a 2%m monthly interest rate after 60 days.
I have read this financial policy and understand and agree to its terms.
HIPPA NOTICE: I authorize release of Information for insurance and collection purposes. The HIPPA policies are available for inspection and review in our office.
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:_____