Family Dental Clinic

FAMILY DENTAL CLINIC, PA

PATIENT REGISTRATION

NAME_____(____)_____BIRTHDATE_____/_____/_____

ADDRESS: _____ CITY: _____ST:____ZIP:_____

PHONE: HM: _____CELL: _____WK: _____

SEX: M / F MARRIED___SINGLE____

WOULD YOU LIKE REMINDERS BY: EMAIL _____TEXT_____PHONE _____

EMAIL ADDRESS:_____

WHO DO WE THANK FOR REFERRING YOU:_____

EMERGENCY CONTACT:_____PHONE:_____RELATIONSHIP_____

PERSON RESPONSIBLE FOR THIS ACCOUNT IF NOT THE PATIENT

NAME:_____

PRIMARY INSURANCE

NAME OF
SUBSCRIBER:_____DOB:_____/_____/_____RELATIONSHIP:_____

PHONE: HOME:_____WORK:_____CELL:_____

ADDRESS (IF DIFFERENT FROM PATIENT):_____

EMPLOYER:_____GROUP #:_____

SUBSCRIBER ID:_____SOCIAL SECURITY:_____-_____-_____

INSURANCE COMPANY_____PHONE_____

SECONDARY INSURANCE

NAME OF
SUBSCRIBER:_____DOB:___/___/____RELATIONSHIP:_____

PHONE: HM:_____WK:_____CELL:_____

EMPLOYER:_____ GROUP_____

SIGNATURE_____DATE:_____/_____/_____

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Family Dental Clinic, PA

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	

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 use controlled substances? Yes No 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 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:_____

Dental History Form

YES / NO

Y N Is it important for you to keep your teeth?
Y N Are you satisfied with the appearance of your teeth?
Y N Does food frequently get caught between teeth?
Y N Do your gums often bleed while brushing?
Y N Have you noticed loosening of your teeth?
Y N Have you injured your head, neck, or jaw?
Y N Do you have difficulty eating or swallowing?
Y N Does your mouth feel dry?

Problems of the jaw- have you noticed…

Y N Clicking of the jaw?
Y N Pain (joint, ear, side of face)?
Y N Difficulty opening or closing?
Y N Difficulty chewing?

Oral habits- Do you…

Y N Clench or grind your teeth?
Y N Bite your lips or cheek frequently?
Y N Smoke or use chewing tobacco? Which type _____

Have you had…

Y N Orthodontic treatment (braces)?
Y N Oral Surgery?
Y N Periodontal/gum treatment (deep cleaning or scaling)?
Y N A bite plane/guard or other appliance?

Do you currently have…

Y N Dental pain?
Y N Sores or swellings in your mouth?
Y N A partial/full denture or dental implants?
Y N Any unfinished dental work?
Y N Have you had any difficulty with dental treatment?

How often do you brush your teeth? _____

What type of toothbrush do you use? Manual / Electric

Do you clean between your teeth? Yes / No

Approximately how long ago were you last seen by a dentist?_____

Reason for today's visit? _____

_____

Family Dental Clinic 

Family Dental Clinic Financial Policy

We are committed to providing you with the best possible care. In order to accomplish these goals, we need your assistance, and your understanding of our payment policy. **It is our policy to charge a fee of $75.00 for a missed appointment unless we receive at least a 24 hours notice.**

There are four payment options, which you may choose from:

1. The total sum of the treatment is paid before, or as the treatment is completed, by check, cash or credit card with a 5% discount.

2. The full insurance co-payment is paid by check or credit card at the time of each appointment.

3. The initial payment is 1/3 of the total. The balance is paid in two equal monthly installments.

4. Interest free loan options are available.

An initial payment will need to be made for dental treatment requiring outside dental laboratory work.

If payment is not received by the due date each month, it is the office policy to assign a late charge of $5.00 to the balance. Returned checks will be charged a fee of $30.00.

Balances older than 60 days may be subject to finance charge of 1.33% per month. (16% APR)

I understand that my insurance is in agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

Sign name for policy and insurance agreement: _____

Print name: _____ Date: _____

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