

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle one: Single Married Divorced Widowed Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian of Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ SS# of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFORMATION**: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Someone NOT living with you) Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information** (Policyholder Information):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is strictly confidential and WILL NOT be released to anyone without your consent. It is important, for your safety that the Doctor knows about your Medical and Dental history. Please make sure this form is accurately completed to the best of your knowledge.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Medical History:**

Do you currently have health problems? ……………………………………………………………………………………………………… Yes/No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a Physician? ………………………………………………………………………………………………………… Yes/No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized within the last 5 years? …………………………………………………………………………………….. Yes/No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications that you are taking, including non-prescription drugs:

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |

Have you ever had an allergic or adverse reaction to any of the following? If so, please circle:

Local Anesthetics Penicillin Ibuprofen

Topical Anesthetics Erythromycin Codeine

Nitrous Oxide Sulfa Latex

Iodine Aspirin Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women Only:**

Are you pregnant? ……………………………………………………………………………………………………………………………………….. Yes/No

 If yes, what is the estimated due date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing? ………………………………………………………………………………………………………………………………………….. Yes/No

Do you take oral contraceptives? …………………………………………………………………………………………………………………. Yes/No

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Do you currently or have you ever had any of the following conditions? Please **circle** as it applies:

Heart Trouble Hepatitis A (infection) Asthma

Heart Attack Hepatitis B (serum) Emphysema

Open-Heart Surgery Hepatitis C Autoimmune Disease

Tuberculosis (TB) Liver Disease Multiple Sclerosis

Heart Pacemaker Kidney Disease Shortness of Breath

Artificial Heart Valve Bleeding Disorder Sinus Trouble

Mitral Valve Prolapse Anemia Head/Neck Injury

Congenital Heart Defect HIV Gout

Rheumatic Fever AIDS Arthritis

Rheumatic Heart Failure Drug Addiction Seasonal Allergies

Angina (chest pain) Alcoholism Steroid Therapy

Congestive Heart Failure Diabetes Glaucoma

Swollen Ankles Ulcers Tumors/Growths

High Blood Pressure Fainting Spells Cancers

Low Blood Pressure Epilepsy/Seizures Chemo/Radiation

Artificial Joint/Implant Stroke Organ Transplant

Thyroid Problem Sexually Transmitted Disease Marked Weight Change

Other Medical Problems:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Insurance Consent

As a courtesy, Eagle Mountain Dentistry will file your insurance claim and assist in collecting from the insurance company. However, Eagle Mountain Dentistry do not render services on the assumption that our charges will be paid by the insurance company. The “patient portion” *is only an estimate,* and in the event that the insurance company pays less than the estimated amount, **you are responsible for the unpaid portion.**

We would also like to inform you that most (but not all) insurance companies allow the benefit of amalgam (silver/mercury) fillings instead of composite fillings (tooth colored) and the benefit of full cast crown (metal/gold) instead of porcelain fused to high noble metal crowns on posterior (back) teeth. The cost difference between the two is usually minimal but please be aware, **you will be responsible for the amount that your insurance does not cover.** If your insurance does downgrade, we will provide you with the estimate based on the adjusted fee.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient Consent Form

Eagle Mountain Dentistry

I understand that, under the Health Insurance Portability & Accountability Act OF 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information have informed me. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient Dental History***

***Name of Previous Dentist and Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date of Last Dental Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*(Please circle below as it applies and elaborate in the space provided as applicable)*

*Yes No Do your gums bleed while brushing or flossing?*

*Yes No Are your teeth sensitive to hot/cold liquid/foods?*

*Yes No Are your teeth sensitive to sweet or sour liquids/foods?*

*Yes No Do you feel any pain in any of your teeth?*

*Yes No Do you have any sores or lumps in or near your mouth?*

*Yes No Have you ever had any head, neck or jaw injuries?*

 *(Have you ever experienced any of the following problems in your jaw?)*

*Yes No Clicking?*

*Yes No Pain in your joint, ear, side of face?*

*Yes No Difficulty in opening or closing or chewing?*

*Yes No Do you use tobacco?*

*Yes No Do you have any other condition, disease, or problem not contained herein that should be*

 *brought to the dentist’s attention? Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*

*Yes No Have you ever experienced trouble associated with any previous dental treatment? Please*

 *explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Yes No Do you have frequent headaches?*

*Yes No Do you clench or grind your teeth?*

*Yes No Do you bite your lips or cheeks frequently?*

*Yes No Have you ever had any previous difficulty with extractions?*

*Yes No Have you ever had any prolonged bleeding following extractions?*

*Yes No Have you ever had any orthodontic treatment (braces)?*

*Yes No Do you wear dentures/partial dentures? If yes, previous date of placement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Yes No Have you ever received oral hygiene instructions regarding the care of your teeth and gums?*

*Yes No Do you like your smile? If no, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Appointment Cancellation Policy**

 At *Eagle Mountain Dentistry* we thrive on the value of dental care that each patient receives with every appointment. Our staff spends time meticulously preparing for your appointment by sterilizing, organizing and arranging your dental treatment room prior to your arrival. Our stringent policy allows us to schedule one patient at a time, rarely double booking patients as Dr. Kim places a high value on quality time with each patient. We understand that unplanned issues can come up and you may need to cancel your appointment, if that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. If you have three appointments cancelled in less than 24 hours or you do not show up for your appointment, our office will **only** be able to schedule a same day appointment for you going forward.

Thank you for being a valued patient and for your understanding and cooperation.

Staff of Eagle Mountain Dentistry

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian signature Date