PATIENT REGISTRATION

Patient Irst Policy Holder Responsible Party Preferred Name:	ID:	Chart ID:					
Responsible Party (if someone other than the patient)	First Name:		Last Name:			Middle Initial:	
	Patient Is: Policy Holo	ler Responsible Party	Preferred Name:				
Address:	Responsible Party (is	f someone other than the patient	t) ———				
Pager Page	First Name:		Last Name:			Middle Initial:	
Mone Work Phone: Esst Cellular: Printary Insurance Policy Holder Patient Pati	Address:		Address 2	2:			
File	City, State, Zip:					Pager:	
Responsible Party is also a Policy Holder for Patient		Work Ph	one:		Ext:		
Patient Information	Birth Date:	Soc Sec:			Drivers Lic:		
Address:	Responsible Party is also	Primary Insurance Po	olicy Holder	Iolder Secondary Insurance Policy Holder			
City:	Patient Information -						
Home Phone: Ext: Celtular: Phone Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Sex: Male Female Age: Soc Sec: Drivers Lic: E-mail: lwould like to receive correspondences via e-mail. Section 2	Address:		Address 2	:			
Phone: Work Finds: Ext: Cellular: Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Birth Date: Age: Soc Sec: Drivers Lie: E-mail: I would like to receive correspondences via e-mail. Section 2	City:		State / Zip:			Pager:	
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed		Work Pho	one:		Ext:		
Birth Date:	Sex: Male	Female	Marital Status: Ma	arried Single	Divorced	Separated Widowed	
Section 2 Employment Full Time	Birth Date:	А					
Section 2	E-mail:		Iw	vould like to receive co	rrespondences vi	ı e-mail.	
Employment Full Time Part Time Retired Referred By Previous Dentist Emergency Contact Emerge	\$100000 Barrier Barrie	- Section 2					
Student Status: Full Time		Time Part Time	Retired	1			
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Time 10:49 AM Michael Su, D.M.D. Date 4/11/2015 **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 Are you under a physician's care now? O Yes O No If yes Have you ever been hospitalized or had a major O Yes O No If yes operation? 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? O Yes O No If ves Have you ever taken Fosamax, Boniva, Actonel or Yes No If yes any other medications containing bisphosphonates? 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? Yes No AIDS/HIV Positive Yes No Cortisone Medicine Hemophilia Yes No Radiation Treatments O Yes O No O Yes O No Alzheimer's Disease Diahetes Yes No Hepatitis A Yes No Yes No Recent Weight Loss Yes No Yes No Anaphylaxis Drug Addiction O Yes O No Hepatitis B or C Yes No Renal Dialysis Yes No Anemia Easily Winded O Yes O No O Yes O No Herpes Rheumatic Fever Yes No Angina O Yes O No Yes No Emphysema O Yes O No High Blood Pressure Rheumatism O Yes O No Yes No Arthritis/Gout O Yes O No Epilepsy or Seizures High Cholesterol O Yes O No Scarlet Fever O Yes O No O Yes O No Artificial Heart Valve O Yes O No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Sickle Cell Disease Yes No Yes No Asthma Fainting Spells/Dizziness Yes No Yes No Irregular Heartbeat Sinus Trouble Yes No O Yes O No **Blood Disease** Yes No Frequent Cough Kidney Problems Yes No Spina Bifida Yes No O Yes O No Blood Transfusion Yes No Frequent Diarrhea Leukemia Yes No Stomach/Intestinal Disease O Yes O No Yes No Breathing Problems Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No Bruise Easily O Yes O No Genital Herpes Yes No Yes No Low Blood Pressure O Yes O No Swelling of Limbs O Yes O No Yes No Cancer Glaucoma O Yes O No Lung Disease Thyroid Disease O Yes O No Yes No Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Tonsillitis Yes No Yes No O Yes O No Chest Pains O Yes O No Heart Attack/Failure Osteoporosis Tuberculosis O Yes O No Cold Sores/Fever Blisters @ Yes @ No O Yes O No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Congenital Heart Disorder Yes No Yes No Heart Pacemaker Parathyroid Disease O Yes O No O Yes O No Illcers Convulsions Yes No Heart Trouble/Disease Yes No Yes No Psychiatric Care Venereal Disease Yes No Yellow Jaundice Yes No

If yes

Yes No

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:

Comments:

Have you ever had any serious illness not listed

* *			
X			
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