Patient Registration

Patient Information:

First Name: _____ Last Name: _____ M: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Ext.: _____ Cell: _____

Sex:____ Male ___ Female Marital Status:____ Married ___ Single ___ Divorced ___ Separated ___ Widowed

DOB: _____SSN: _____Drivers Lic. #: _____ State: _____

Email: _____ (Parent Email if Minor)

** **Email is used for reminders, appointment confirmations and newsletters/promotions****

Emergency Contact: _____ Phone #: _____

Primary Dental Insurance Information:

Insured First Name: _____ Last Name: _____ M: ____

Insured DOB: _____ Insured SSN: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Employer: _____

Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other _____

** **We do not file Secondary Dental Insurance** **

Parent Information (Complete only if Patient is a Minor):

Mother's Name: First: _____ Last: _____ M: _____

DOB: _____ SSN: _____ Drivers Lic. #: _____ State: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Father's Name: First: _____ Last: _____ M: _____

DOB: _____ SSN: _____ Drivers Lic. #: _____ State: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

EDWARD RATHER JR. D.M.D.

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:_____

Financial Policy

We are a fee for service practice. As a convenience to our patients we will file a claim with your insurance company. Insurance coverage is a contract between the patient and his/her insurance carrier. We cannot guarantee if, how, or when your insurance company pays. Patients who carry dental insurance understand that all dental services furnished are charged in full directly to the patient.

Payment Options:

_____ 1) Patients without insurance: Payment in full is due at time of treatment.

_____ 2) We will estimate what your out-of-pocket expense will be and this amount is due at time of treatment. As a courtesy, we will file with your insurance carrier. We will allow up to 45 days for your insurance to remit payment. When we receive payment from your insurance company, any balance left unpaid will be charged to your account.

**By signing below, you allow us to release information to your insurance company for the purpose of claim filing and you allow your insurance company to release assignment of benefits to us if applicable.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fee if suit be instituted hereunder.

** By signing this form, you acknowledge and understand that all payments are due at the time services are rendered. Also be advised that we do use a collection company for any defaulted balances. Accounts that are sent to collections will then be responsible for the defaulted balance, plus a 50% collection fee. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to the form.

Payment Options:

1) Cash – includes money orders and personal checks
2) All Major Credit Cards
3) Care Credit (we have brochures for more information)

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of guarantor of payment/responsible party