Dental Registration and History

Thank you for choosing us. We appreciate your business.

PATIENT INFORMATION				
Patient's name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Preferred name:		Birth date:		Sex: ❑ M ❑ F
Street address:		P.O. Box		Social Security no:
City	State	Zip Code		Preferred contact method ❑Home ❑Cell ❑Email
E-mail:		Home phone : ( )		Cell phone: ( )
Occupation:	Employer:			Employer phone no.:
Spouse or Parent Name:	Relationship:	Home phone: ( )	Cell phone: ( )	Birthdate:
Social Security no:	Employer:			Occupation:
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Family ❑ Friend ❑ Website ❑ Yellow Pages ❑Other				

DENTAL INSURANCE				
Person responsible for bill:	Relationship:			Home phone no.: ( )
Employer:	Occupation:			Employer phone no.: ( )
Insurance Company:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Martin E. Poarch, DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party signature:_____Date:_____

Martin E. Poarch, D.D.S.

Eaglesoft Medical History(Copy)(Copy)

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

Do you have a primary care physician?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ 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
☐ Cinnamon/Mint/Strawberry

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Hepatitis A	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No
Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Artificial Joint	○ 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	Blood Transfusion	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Stroke	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Cancer	○ Yes ○ No	Chemotherapy	○ 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
Heart Trouble/Disease	○ 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:_____