PATIENT REGISTRATION

PATIENT INFORMATION

First Name:____________________ **Last Name:**____________________

Middle Initial:__________ **Preferred Name:**____________________

Sex: (M) (F) (Unknown)

Address:________________________ **City, State, Zip:**____________________

Home Phone: (___)__________ **Work Phone: (___)**__________ **Ext:**______

Cell Phone: (___)__________ **Birth Date:**__________

Soc Sec # ______________

Marital Status: (Married) (Single) (Divorced) (Separated) (Widowed)

Spouses Name:____________________

Emergency Contact #: (___)__________ **Relationship:**______________

PRIMARY MEDICAL INSURANCE INFORMATION:

Name of Insured:______________________________

Relationship to Insured: (Self) (Spouse) (Child)

Insured Soc Sec #: ____-___-____ **Insured Birth Date:**__________

Insurance ID #:__________ **Employer:**________________________

Insurance Carrier:____________________

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured:______________________________

Relationship to Insured: (Self) (Spouse) (Child)

Insured Soc Sec #: ____-___-____ **Insured Birth Date:**___________

Insurance ID #:___________ **Employer:**_________________________

Insurance Carrier:______________________

City, State, Zip:_______________________________

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insured:______________________________

Relationship to Insured: (Self) (Spouse) (Child)

Insured Soc Sec #: ____-___-____ **Insured Birth Date:**___________

Insurance ID #:___________ **Employer:**_________________________

Insurance Carrier:______________________

City, State, Zip:_______________________________

Time 12:03 PM

Warren M. Krutchick D.D.S

Date 10/29/2014

Eaglesoft Medical History 2014/2015

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.

Who is Your Primary Physician

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

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

What Pharmacy Do You Use?

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do You Snore? ◯ Yes ◯ No

Have you ever had a Sleep Study ◯ 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 ☐ Latex
☐ Sulfa Drugs ☐ Local Anesthetics ☐ Bees

Do you use controlled substances? ◯ Yes ◯ No If yes

Other? ☐ If yes

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

Condition		Condition		Condition		Condition	
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	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
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	Yellow Jaundice	◯ Yes ◯ No	COPD	◯ Yes ◯ No	Depression	◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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:__________