

**Birmingham Smiles Dentistry**

**PLEASE PRINT PATIENT REGISTRATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

**PATIENT INFORMATION:**

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

EMAIL: \_\_\_\_\_

HomePhone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

SOC SEC: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ SEX \_\_\_\_\_ MALE  
\_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_ FEMALE

STUDENT STATUS: \_\_\_\_\_ FULL TIME \_\_\_\_\_ PART TIME NAME OF COLLEGE \_\_\_\_\_

EMPLOYMENT STATUS: \_\_\_\_\_ FULL TIME \_\_\_\_\_ PART TIME \_\_\_\_\_ RETIRED

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

**PRIMARY DENTAL INSURANCE INFORMATION:**

Name of Insured \_\_\_\_\_

Employer of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Parent/Guardian

Insured Social Security \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Name of Ins. Company \_\_\_\_\_

Group Number \_\_\_\_\_ ID/Policy Number \_\_\_\_\_

**SECONDARY DENTAL INSURANCE INFORMATION:**

Name of Insured \_\_\_\_\_

Employer of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Parent/Guardian

Name of Ins. Co. \_\_\_\_\_

Group Number \_\_\_\_\_ ID/Policy \_\_\_\_\_

**PLEASE READ AND SIGN NEXT PAGE**

**RESPONSIBLE PARTY INFORMATION:**

FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_ DRIVER'S LICENSE \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

RELATION: \_\_\_\_\_

THE ABOVE INFORMATION IS TRUE AND I WILL NOTIFY YOU OF ANY CHANGES:

**IN THE EVENT OF NON-PAYMENT OF CHARGES FOR DENTAL SERVICES RENDERED, I AGREE TO PAY ALL COST OF COLLECTION , INCLUDING ATTORNEY'S FEE , COURT COST AND I FURTHER AGREE TO PAY THE LEGAL RATE OF INTEREST ON THE ACCOUNT UNTIL PAID IN FULL AND HEREBY WAIVE ALL RIGHTS OF EXEMPTION UNDER THE CONSTITUTIONAL LAWS OF STATE OF AL. I HAVE READ THIS CONTRACT AND UNDERSTAND ITS PROVISIONS. INTEREST WILL BE CHARGED AND WILL BE ADDED TO ALL ACCOUNTS 30 DAYS PAST DUE.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**I have read the Privacy Notice and understand my rights contained in the notice.**

**By way of my signature. I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the privacy notice.**

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**Patient's Name (print)**

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**Patient's Signature**

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**Date**

### 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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 90%;" type="text"/>

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed above?  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: \_\_\_\_\_