PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

WESTWORTH VILLAGE FAMILY DENTISTRY

WHEN WAS YOUR LAST DENTAL CLEANING? _____

WHAT IS THE REASON FOR YOUR DENTAL VISIT TODAY?

_____

_____

DISCOLORED OR DARK TEETH	___ YES ___ NO
CHIPPED, THIN OR WORN DOWN TEETH	___ YES ___ NO
TMJ, JAW OR MUSCLE SORENESS/PAIN	___ YES ___ NO
CROWDED OR CROOKED TEETH	___ YES ___NO
FREQUENT HEADACHES OR MIGRAINES	___ YES ___ NO
HISTORY OF ORTHODONTIC TREATMENT	___ YES ___ NO
DO YOU HAVE A NIGHTGUARD	___ YES ___ NO
HOW OFTEN DO YOU WEAR YOUR NIGHTGUARD	_____
ANY HISTORY OF GUM DISEASE	___ YES ___NO
DO YOU COVER YOUR MOUTH WHEN YOU SMILE	___ YES ___ NO
RED, SWOLLEN, BLEEDING OR RECEDING GUMS	___ YES ___ NO
ANXIETY WITH DENTAL WORK/DENTAL FEAR	___ YES ___ NO
ARE YOUR TEETH SENSITIVE TO HOT OR COLD	___ YES ___ NO
HOW MANY TIMES PER DAY DO YOU BRUSH	_____
HOW OFTEN DO YOU FLOSS YOUR TEETH	_____

PATIENT'S NAME _____

RESPONSIBLE PARTY IF PATIENT IS UNDER 18 YEARS OLD _____

SIGNATURE _____ DATE _____

Eaglesoft Medical History (Revised 1-17-2023)

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, c

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 use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you have sleep apnea?	◯ Yes ◯ No	
Do you snore?	◯ Yes ◯ No	

Women: Are you...

☐ 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 ◯ 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	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			

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:_____

FINANCIAL POLICY

We appreciate the opportunity to serve you! We have found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

♦ **Patients without insurance coverage need to know . . .**
The fee for the treatment rendered must be paid in full on the day of service unless another agreement is met between you and Westworth Village Family Dentistry. As a condition of treatment for this office, financial arrangements must be made in writing in advance and signed by both parties. Financial responsibility on the part of each patient must be determined before treatment.

♦ **Patients with insurance coverage need to know . . .**
The estimated patient co-pay and deductible for the treatment rendered must be paid in full on the day of service. We will file insurance claims for you as a courtesy. Please understand that your insurance policy is a contract between you and your insurance company. We have no control over their decisions to pay on the claims nor the amount they decide to pay. Please understand that you are ultimately responsible for all fees generated by your treatment.

♦ **We accept cash, checks, and most major credit cards. There will be a $25 fee on any returned checks.**

♦ **24 hours notice is required for rescheduling appointments.**
A $50 fee will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 24 hours notice.

This is an agreement between Westworth Village Family Dentistry, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you consent to treatment by Westworth Village Family Dentistry and her staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name (please print):_____

Responsible Party (if patient is under18 years old):_____

Signature:_____Date:_____

Please initial each section.

___ **PHOTOGRAPHY RELEASE**

I understand that photographs and x-rays will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising, and professional publications. My identity will be protected if any of my records are used in accordance to the HIPPA laws.

___ **APPOINTMENTS**

If I am more than 15 minutes late for my appointment time without reasonable explanation, I will be required to reschedule and pay the $50.00 broken appointment fee.

___ **EMERGENCY CARE**

It is our philosophy to be available to any patient in discomfort, or in an emergency situation. This courtesy is extended to all patients and we ask for your cooperation to only use the emergency contact line for true emergencies, such as, a broken tooth or severe dental infection causing swelling and pain. Please leave contact information and brief message.

Patient's Name (please print):_____

Responsible Party (if patient is under18 years old):_____

Signature: _____Date:_____