PATIENT REGISTRATION

ID:	Chart ID:					
irst Name:		Last Name:				Middle Initial:
Patient Is: Policy Holder	Responsible Party	Preferred Name:				
Responsible Party (if sor	meone other than the patient) -					
First Name:		Last Name:				Middle Initial:
Address:		Address	s 2:			
City, State, Zip:						Pager:
Home Phone:	Work Phone:			Ext:	(Cellular:
Birth Date:	Soc Sec:			Driv	vers Lic:	
Responsible Party is also a I	Policy Holder for Patient	Primary Insurance	Primary Insurance Policy Holder Secondary			
Patient Information —	Sec. 1					
Address:		Address	2:			
City:		State / Zip:				Pager:
Home Phone:	Work Phone:	*		Ext:	C	Cellular:
Sex: Male]Female	Marital Status:	Married Single	Divorce	d Separated	Widowed
Birth Date:	Age:	Soc S	Sec:	Driv	ers Lic:	
E-mail:		1	would like to receive o	correspondences	via e-mail.	
	Section 2				Section	3 —
Employment Full Tim	e Part Time	Retired			Credit Card# Exp Date	
Student Status: Full Tim	e Part Time				Card Type	
Medicaid ID:	Pref. Den	tist			Name on card	
Employer ID:	Pref. Pharma	acy:				
Carrier ID:	Pref. H	lyg:	1			
Primary Insurance Inform	ation —					
Name of Insured:			Relationship to Insur	red: Self	Spouse	Child Other
Insured Soc. Sec:		Insured Birth Da				
Employer:		- 1	Ins. Company	v:		
Address:			Address			
Address 2:			Address 2	2:		
City, State, Zip:			City, State, Zip	0.		
Rem. Benefits:	Rem	. Deduct:				
 Secondary Insurance Info 	rmation —					
Name of Insured:			Relationship to Insur	red: Self	Spouse	Child Other
Insured Soc. Sec:		Insured Birth Da	te:			
Employer:			Ins. Company	y:		
Address:			Address	s:		
Address 2:			Address 2	2:		
City, State, Zip:			City, State, Zip):		
Rem Renefits:	Rem	Deduct:				

Bita Tahvidari, DDS Eaglesoft Medical History

Birth Date:

Date Created:

Patient Name:

Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Manemia Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Manemia Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Manemia Yes No Easily Winded Yes No High Blood Pressure Yes No Rheumatic Fever High Blood Pressure Yes No Rheumatic Fever Migh Blood Pressure Yes No Rheumatism Manematism Manematism Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Migh Cholesterol Yes No Scarlet Fever Might Cholesterol Yes No Heart Might Cholesterol Yes No Heart Might Cholesterol Yes No Uncers No Winder Alabach Cholesterol Yes No Uncers No Winder Alabac	gh dental personnel primarily tr	at the area in and	around yo	our mout	h, your r	mouth is a part of your er	tire body. Healt	h problems that you may h	ave, or medic
operation? Are you taken or have you taken, Phen-Fen or Redux? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No Do you sever taken Fosemax, Bonke, Actonel or any other medications containing bisphosphonates? Are you are special diet? Yes No Do you use tobacco? Nomen: Are you Pregnant/Trying to get pregnant? Nursing? Nursing? Taking oral contraceptives? Nomen: Are you Pregnant/Trying to get pregnant? Nursing? Nursing? Taking oral contraceptives? Nomen: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Nomen: Are you Pregnant/Trying to get pregnant? Nursing? Acrylic Metal Latex Suffa Drugs Acrylic Acrylic Metal Latex Suffa Drugs Acrylic Metal Codeine Acrylic Ac	re you under a physician's care now?		⊕ Yes ∈	No.	If ves				
Are you taking any medications, pills, or drugs? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Oover any other medications containing bisphosphonates? Yes No Oover any other following? Actificial substances? Yes No Oover any other follo			⊕ Yes €	No	If ves				
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 bisphosphonoties? Are you on a Special diet? Do you use tobacco? Yes No Do you use tobacco? Yes No Yes No Taking oral contraceptives? Torriging oral contraceptives			○ Yes €	No	If yes				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Ves No Ves No Ves No Ves No Ves No Ves No Taking oral contraceptives? To you alergic to any of the following? Aspirin Penicillin Codeine Acrylic Sulfa Drugs Codeine Ac	Are you taking any medications, pills, or drugs?		Yes ∈	No	If yes				
any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? Yes No Pregnant/Trying to get pregnant? re you alergic to any of the following? Aspirin	Do you take, or have you taken, Phen-Fen or Redux?		⊕ Yes €	No	If ves				
Do you use tobacco? Yes No	Have you ever taken Fosamax, Boniva, Actonel or		⊕ Yes ∈	No No	If ves				
Taking oral contraceptives? Taki	u on a special diet?		○ Yes €	No.					
Pregnant/Trying to get pregnant? Nursing?	7. # EG. 200 W. B. D. A. W. B. D.		⊕ Yes ⊕ No						
re you alergic to any of the following? Aspirin Aspirin Penicillin Latex Sulfa Drugs Local Anesthetics Other? Do you use controlled substances? Yes No ADS/HIV Positive Yes No Albeimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Emphysema Yes No Artificial Joint Yes No Artificial Joint Yes No Blood Disease Yes No Blood Disease Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problems Yes No Breathing Problems Yes No Cement Headaches Yes No Cement Headaches Yes No Cement Headaches Yes No Ceneur Yes No Cement Headaches Yes No Chest Pains Yes No Cement Headaches Yes No Chest Pains Yes No Chest Pains Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Congerial Heart Disorder Yes No Convulsions Penicillin Codeine Sulfa Drugs Local Anesthetics Leves No Rediation Treatments Republita A Yes No Recent Weight Loss Recent Weigh	Are you								
Aspirin Penicillin Latex Sulfa Drugs Acrylic Local Anesthetics Other?			Nursing	g?			Taking or	ral contraceptives?	
Metal Latex Sulfa Drugs Local Anesthetics Other?	allergic to any of the following?								
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Angina			on			Hepatitis B or C		Renal Dialysis	O Yes O N
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Artificial Heart Valve								Rheumatism	O Yes O N
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Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Chest Pains Yes No Cold Sores/Fever Bisters Yes No Convulsions Yes No Heart Trouble/Disease Yes No No Convulsions Yes	ning Problems 💮 Yes 🗇 N	Frequent He	adaches	Yes	⊕ No	Liver Disease	Yes No	Stroke	O Yes O N
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Chest Pains Yes No Cold Sores/Fever Bisters Yes No Congenital Heart Disorder Yes No Convulsions Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Yes No Ulcers Venereal Disease Yellow Jaundice	r 💮 Yes 🗇 N	Glaucoma		O Yes	○ No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O N
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Congenital Heart Disorder (Yes No No Convulsions (Yes No	Pains Yes O N	Heart Attack	/Failure	O Yes	⊕ No	Osteoporosis	○ Yes ○ No	Tuberculosis	O Yes O N
Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yellow Jaundice	ores/Fever Bisters 🖱 Yes 🕕 N	Heart Murmi	ır	O Yes	⊕ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	O Yes O N
Yellow Jaundice 🗇	nital Heart Disorder 💮 Yes 💮 N	Heart Pacem	aker	O Yes	⊕ No	Parathyroid Disease	Yes No	Ulcers	O Yes O N
	Ísions 🔘 Yes 🗇 N	Heart Troubl	le/Disease	O Yes	⊕ No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O N
lave you ever had any serious illness not listed								Yellow Jaundice	⊕ Yes ⊕ N
	ou ever had any serious illnes	not listed	⊕ Yes €	No.	If yes				
omments:	its:								

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: