Fresh Smiles

PATIENT REGISTRATION DATE:_____ PAGE 1

FIRST NAME:_____ MI:____ LAST NAME:_____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

HOME PHONE #:_____ CELL PHONE #_____

EMAIL: _____

DATE OF BIRTH:_____ AGE:_____ SOC SEC #:_____

SEX: M / F MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

EMPLOYER NAME & ADDRESS_____

PREFERRED PHARMACY & PHONE #:_____

_____

PERSON RESPONSIBLE FOR ACCOUNT (IF SOMEONE OTHER THAN PATIENT)

_____SSN:_____

DOB:_____RELATIONSHIP:_____

ADDRESS (IF DIFFERENT):_____

EMPLOYER NAME & ADDRESS_____

EMPLOYER PHONE #_____

_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED:_____ PATIENTS RELATIONSHIP TO INSURED:_____

INSURED SOC SEC #:_____ INSURED DATE OF BIRTH:_____

INSURANCE COMPANY:_____

ADDRESS:_____

PHONE #_____ ID # ON CARD:_____

_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED:_____

PATIENTS RELATIONSHIP TO INSURED:_____

INSURED SOC SEC #:_____ INSURED DATE OF BIRTH:_____

INSURANCE COMPANY:_____

ADDRESS:_____

PHONE #_____ ID # ON CARD:_____

INSURED EMPLOYER:_____

Fresh Smiles

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PATIENT NAME:_____

ADDRESS:_____

Which of the following communications means are appropriate/acceptable for MFD to communicate with you (please check all that apply)

Home phone _____ Ok to leave a message? _____YES _____NO

Cell phone _____ Ok to leave a message? _____YES _____NO

Work phone _____ Ok to leave a message? _____YES _____NO

Which method of communication is preferred? _____No contact _____Mail ____Phone ____Email

With whom may we share information about your Dental care? PLEASE LIST BELOW

Note: In order for to disclose your private dental information, the representative listed must be able to provide (2) two forms of identification. 1. Last 4 of patient's SSN 2. Patient's DOB

AUTHORIZATION TO DISCLOSE DENTAL INFORMATION

Name	Relationship	Phone #	MAY DISCUSS TREATMENT	MAY DISCUSS BILLING
_____			YES___NO____	YES___NO____
_____			YES___NO____	YES___NO____
EMERGENCY CONTACT:				
_____			YES___NO____	YES___NO____

Do you have a legal document that states who will make decisions if you are unable? _____yes _____no

If yes, Name_____Relationship_____

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's dental information.

Patient/Legal Representative
Signature:_____Date:_____

Fresh Smiles
AT MAGNOLIA FAMILY DENTISTRY

AUTHORIZATIONS, ACKNOWLEDGEMENTS

PATIENT NAME:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

*INITIAL HERE*_____I ACKNOWLEDGE THAT A COPY OF THE NOTICE OF PRIVACE PRACTICES WAS MADE AVAILABLE TO ME.

GENERAL CONSENT TO TREATMENT

*INITIAL HERE*_____ I CONSENT TO EXAMINATION BY DR. BRELAND AND OTHER DENTAL PROFESSIONALS AT THIS CLINIC. I ALSO CONSENT TO ANY DENTAL PROCEDURES, X-RAY, LABORATORY TESTS OR OTHER DENTAL CARE SERVICES ORDERED BY THE DENTAL CARE TEAM. I UNDERSTAND THAT I MAY REFUSE SPECIFIC TREATMENTS OR PROCEDURES BY INFORMING THE DENTAL CARE TEAM.

RELEASE OF INFORMATION

*INITIAL HERE*_____I AUTHORIZE MAGNOLIA FAMILY DENTAL TO RELEASE ANY DENTAL INFORMATION NECESSARY TO PROCESS PAYMENT OF MY CLAIM.

COMMUNICATIONS REGARDING MY ACCOUNT

*INITIAL HERE*_____I AGREE THAT THE FACILITY, MAGNOLIA FAMILY DENTAL OR ANY OTHER COLLECTION AGENCY OR AGENCIES RETAINED BY MAGNOLIA FAMILIY DENTISTRY TO COLLECT ANY MONEY THAT I OWE TO THE FACILITY. THEY MAY CONTACT ME BY TELEPHONE OR TEXT MESSAGE AT ANY NUMBER GIVEN BY ME. I UNDERSTAND THAT IF I DEFAULT ON PAYMENT THAT COLLECTION FEES AND/OR COURT COST COULD BE ADDED TO MY BALANCE.

DENTAL INSURANCE

*INITIAL HERE*_____ON THE DAY OF YOUR APPOINTMENT, ALL INELIGIBLE MONIES WILL BE COLLECTED (DEDUCTIBLES, CO-PAYS, ETC). THESE MONIES ARE REQUIRED TO BE PAID BY THE PATIENT PER THE INSURANCE COMPANY. IF YOU DO NOT HAVE DENTAL INSURANCE YOU WILL BE EXPECTED TO PAY BEFORE ANY TREATMENT IS PROVIDED.

RESPONSIBILITY

*INITIAL HERE*_____IT IS YOUR RESPONSILIBITY TO PROVIDE US WITH CORRECT INSURANCE INFORMATION. IT IS YOUR RESPONSIBILITY TO KNOW IF WE ARE COVERED BY YOUR INSURANCE CARRIER. WE WILL VERIFY AND FILE YOUR INSURANCE AS A COURTESY BUT YOU ARE ULITMATELY RESPONSIBLE FOR THE CHARGES INCURED.

I UNDERSTAND THAT IF MY INSURANCE DOES NOT PAY WITHIN 60 DAYS THAT I WILL BE BILLED FOR SERVICES.

_____ _____

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZED TO SIGN FOR PATIENT DATE

Eaglesoft Medical History(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, 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?	◯ Yes ◯ No	If yes
Do you use any illegal substances?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
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

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	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis	◯ 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	Genital Herpes	◯ 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	Mouth Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ 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:_____