

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

----- 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.

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Section 2

Employment Status:  Full Time  Part Time  Retired  
 Student Status:  Full Time  Part Time  
 Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_  
 Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_  
 Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

Section 3

Referred By  
 Previous Dentist  
 Emergency Contact  
 Emergency Contact #

----- 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: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

----- 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: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

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, 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 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 bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

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: \_\_\_\_\_

**Gairhan Dental Care**

Emily Gairhan, D.D.S.

460 Southwest Dr., Suite B—Jonesboro, AR 72401

Phone: 870-931-1100 Fax: 870-931-1101

Patient

Name \_\_\_\_\_ Date \_\_\_\_\_

Please place a check in each circle and sign at bottom of page.

**NOTICE OF PRIVACY PRACTICES**

- o I acknowledge that I understand Dr. Emily Gairhan’s HIPAA Notice of Privacy Practices. No Information will be released from this office without my written permission. Copies of Notice of Privacy Practices have been made available to me. I give permission to release any protected information to the following people:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CONSENT FOR SERVICES**

- o I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to my dental health.
- o I grant my permission to the following people to consent to treatment on behalf of my child \_\_\_\_\_(under the age of 18).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FINANCIAL INFORMATION**

- o Payment for services is due on the day services are rendered.
- o I understand I will be informed of the treatment plan and associated fees, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my personal health information to carry out payment activities in conjunctions with a claim.

**CONSENT FOR PHOTOGRAPH PUBLISHING**

- o I grant permission to Gairhan Dental Care to use dental photo and/or x-ray for comparison purposes in our office only. Any further use will be with permission only for that one time usage.
- o I, the undersigned, give my permission to use my photographs, portraits, transparencies, negatives, prints, polaroid's, or other photographic reproductions for use by Gairhan Dental Care.

Patient Name (please print) \_\_\_\_\_

Signature of Patient (parent or guardian) \_\_\_\_\_