

PATIENT REGISTRATION

Last Name: _____ First Name: _____ Preferred Name: _____

Address: _____
Street City, State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Birth date: _____ Social Security #: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed Student Status: ☐ FT ☐ PT

Employer: _____ Occupation: _____ Referred By: _____

Responsible Party (if different from patient)

Last Name: _____ First Name: _____ Relationship to Patient: _____

Address: _____
Street City, State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's Lic #: _____

Primary Insurance Information:

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

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

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

Secondary Insurance Information:

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

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

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

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 type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input 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 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 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	Corticosteroid 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: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to this date I revoked this consent is not in effect.

Signed this date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
 - ☐ Communications barriers prohibited obtaining the acknowledgement
 - ☐ An emergency situation prevented us from obtaining acknowledgement
 - ☐ Other (Please Specify)
-
-

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Responsibility & Dental Treatment Consent Form

Please read, and sign at the bottom of the form.

1. **X-RAYS**
2. **DRUGS AND MEDICATIONS:** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or other anaphylactic shock (severe allergic reaction).
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
4. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
5. **CROWNS, BRIDGES AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which many come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
6. **DENTURES, COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
7. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
8. **PERIODONTAL LOSS (TISSUE & BONE):** I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common effect of a newly placed filling.
9. **FILLINGS:** I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common effect of a newly placed filling.
10. **DENTURES:** I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several inlines. A permanent inline will be needed later. This is not included in the denture fee. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.
11. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.
12. Patients with a family account balance over 60 days will not be seen until the balance is PAID IN FULL. Payment is due at time of service.
13. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes for dental treatment.
14. I understand and acknowledge that I am financially responsible for the services provided for myself or the dependent named regardless of insurance coverage. I am also responsible for any applicable attorney and court fines/ fees.
15. We reserve the right to charge \$50 per scheduled hour, to your account if we do not receive at least a 24-hour notice of cancelled appointments.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian if patient is a minor: _____ Date: _____