

# PATIENT REGISTRATION

## PATIENT INFORMATION

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ SEX: M F BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
If Patient is a Minor, give Parent's or Guardian's Name: \_\_\_\_\_ Reason for this Visit: \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
RESIDENCE Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
MAILING ADDRESS Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME/CELL \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
PREVIOUS ADDRESS (if less than 3 yrs.) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

## RESPONSIBLE PARTY'S SPOUSE

NAME Last/First/Middle Initial \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

## PATIENT INFORMATION

ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME # \_\_\_\_\_ CELL # \_\_\_\_\_

## INSURANCE INFORMATION

EMPLOYEE NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
NAME OF DENTAL BENEFITS PLAN \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_  
INSURANCE PHONE \_\_\_\_\_ GROUP # \_\_\_\_\_  
INSURANCE MAILING ADDRESS \_\_\_\_\_  
EMPLOYEE DATE OF BIRTH \_\_\_\_\_ YRS OF EMPLOYMENT \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
PHONE \_\_\_\_\_ CELL # \_\_\_\_\_

## DO YOU HAVE SECONDARY DENTAL COVERAGE? YES NO

EMPLOYEE NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
NAME OF DENTAL BENEFITS PLAN \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_  
INSURANCE PHONE \_\_\_\_\_ GROUP # \_\_\_\_\_  
INSURANCE MAILING ADDRESS \_\_\_\_\_  
EMPLOYEE DATE OF BIRTH \_\_\_\_\_ YRS OF EMPLOYMENT \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
PHONE \_\_\_\_\_ CELL # \_\_\_\_\_

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME Last \_\_\_\_\_ First \_\_\_\_\_  
ADDRESS, CITY, STATE \_\_\_\_\_  
PHONE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_

**NOTE: INSURANCE COMPANY WILL NOT BE BILLED WITHOUT THE INSURED SIGNATURE FOR AUTHORIZATION.**

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- 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 \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

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 Problem         | <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

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 \_\_\_\_\_ DATE \_\_\_\_\_

# Eureka Family Dental, P.C.

2000 S. Main St. | Eureka, IL 61530 | (309) 467-3515

## WRITTEN FINANCIAL POLICY

Thank you for choosing Eureka Family Dental, P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

### PAYMENT OPTIONS:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card
- NO INTEREST<sup>1</sup> Payment Plans<sup>2</sup> from CareCredit
  - Allow you to pay over time with NO INTEREST<sup>1</sup>
  - Convenient, low monthly payment plans<sup>2</sup> also available
  - No annual fees or pre-payment penalties

Please Note:

Eureka Family Dental, P.C. requires payment prior to or at time of service. Payment arrangements must be made prior to appointments.

For plans requiring more than 1 appointment, alternative payment arrangements may be provided, but MUST be arranged with the office manager prior to the appointments.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>3</sup> Deductibles and copays are due at the time of service.

I have read this information and understand that I am responsible for payment in full of all charges incurred by myself or my family.

Accounts 90 days past due will be subject to an interest fee of 1.5% (18% APR). In the event I fail to make payments in a timely manner, and my account becomes past due, I shall be liable and agree to pay for all collection agency fees (not to exceed 33.3%), reasonable attorney's fees and court costs.

I hereby authorize Eureka Family Dental, P.C. to release any information relating to my claims with this office. I hereby authorize payment of the dental benefits otherwise payable to me, directly to Eureka Family Dental, P.C. A copy of this authorization is valid for claims and can be faxed.

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Insurance Policy Holder Signature

Date

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Patient Name (Please Print)

<sup>1</sup> If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

<sup>2</sup> Subject to credit approval

<sup>3</sup> However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.