

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

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 ☐ Unknown 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.

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 #: _____

Last Dental Visit: _____

Family/Single Cov: _____

Effective Date: _____

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: _____ .00 Rem. Deduct: _____ .00

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: _____ .00 Rem. Deduct: _____ .00

Price Family Cosmetic Dentistry, Inc
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?
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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	Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ 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	Frequent Diarrhea	☐ 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	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: _____

Joel Z. Price Jr. DMD
565 Corley Mill Road
Lexington, SC 29072
(803) 520-4900

Acknowledgement of Receipt of Notice of Privacy Practices

Last Updated July 2026

I _____ have received a copy of the office's Notice of Privacy Practices. (This allows the office to file your insurance claims with your personal information. We will not release any of your information without your consent unless it is to an insurance company.)

Name: _____

Signature: _____

Date: _____

Notification of Appointments

May we leave a message on a voicemail at your home? Yes ____ No ____

May we leave a message with someone other than you at your home number? Yes ____ No ____

May we leave a message on a voicemail at your work number? Yes ____ No ____

May we leave a message with someone other than you at your work number? Yes ____ No ____

May we send you Appointment Reminders via text or email? Yes ____ No ____

FOR OFFICE USE ONLY:

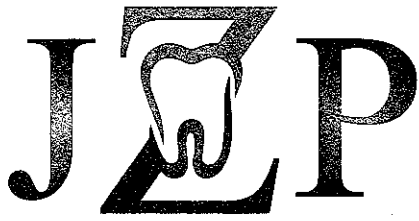
We attempted to obtain written acknowledgement of receipt of our Privacy Practice, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify) _____



JOEL Z. PRICE, JR. DMD
Family and Cosmetic Dentistry

To: _____

I _____ request my records to be released to Joel Z. Price DMD at 565 Corley Mill Road, Lexington, SC 29072.

Name: _____

Date of Birth: _____

Address: _____

This permission form is to comply with Federal HIPAA guidelines as of January 2013.

Signature: _____

Date: _____

OFFICE@JOELPRICEDMD.COM

565 Corley Mill Road • Lexington, SC 29072

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