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.

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

slow payer see acct

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:

New Haven Dental Group

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?	○ 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 ○ 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:_____

Medication List

Name _____Date of Birth_____Today's Date _____.

To provide better service to you while you are in our office, a detailed accurate list of medications is needed. Please include all prescriptions, over-the-counter medications, and all herbal supplements or vitamins.

Name of Medication	Dosage Example: 30 mg	How Many / Frequency Example: 1 daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		
11.		
12.		
13.		
14.		
15.		
16.		
18.		
19.		
20.		

Please list any allergies and the reaction that you may have to them.

Allergies	Reactions
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

HIPPA COMPLILANCE FORM

Patient Information:

Name: _____ Date of Birth: _____

I request that the following be allowed for the disclosure of my protected Health Information. Protected Health Information would include: name, diagnosis, test results, and dates of service.

You may disclose information to my family members or non-family members.

Please list the name, phone number and relationship:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Our office reserves the right to e-mail x-rays and records to other dental/medical facilities and insurance companies. Our office also has the capability of text messaging and emailing information regarding your dental appointment.

Acknowledgement of receipt of privacy practice notice

I acknowledge that I have received a Notice of Privacy practices from New Haven Family Dentistry. I attest that the above information is correct.

Signature: _____ Date: _____

Printed name:_____ Relationship if patient is child: _____

Good faith effort to obtain acknowledgement of receipt

Describe your good faith effort to obtain the individual's signature, and reason why the individual would not sign the form:

_____

_____

New Haven
FAMILY DENTISTRY

Insurance Release and Financial Policy

For those patients who have insurance coverage:

1. In consideration of my doctor rendering dental services to me or a member of my family for whom I am financially responsible, I hereby assign to my doctor all insurance which I have a right to in regard to his/her bill.
2. This assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness.
3. In the event the insurance carrier pays benefits to me (instead of to my doctor as I hereby request) for services performed, I agree that I will immediately deliver all such benefits to my doctor up to the amount of my indebtedness to him.

For those patients who do not have insurance coverage:

If I do not have insurance coverage, I understand that I am financially responsible for all bills incurred during my treatment.

Authorization for release of information:

Dr. Noll is hereby authorized to furnish such professional information as may be necessary for the completion of my insurance claim from the medical records compiled during my treatment. Dr. Noll is hereby released from all legal liability that may arise from the release of the information requested.

I (we) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at discharge, or within (30) thirty days of discharge to pay for in-office processing fees. I (we) further agree to pay collection costs and reasonable attorney fees if this account is placed in the hands of a collection agency or attorney.

Cancellation Policy

If you are unable to keep your appointment, we require at least 24 hours notice so that your reserved time may be made available for other patients. Patients who miss an appointment or cancel with less than 24 hours notice will be assessed a $45 fee.

Late Arrival

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 20 minutes late to your scheduled appointment, you may be asked to reschedule.

I have read the above and foregoing and fully understand the terms thereof.

_____ _____

Signature of Patient/Responsible Party Date

_____

Printed name of Patient/Responsible Party