

**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: \_\_\_\_\_

Gender: ☐ Male ☐ Female ☐ UnknownMarital 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

## Section 3

Employment Status: ☐ Full Time ☐ Part Time ☐ RetiredStudent Status: ☐ Full Time ☐ Part Time

Medicaid ID: \_\_\_\_\_

Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_

Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_

Pref. Hyg: \_\_\_\_\_

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?   | <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 | 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

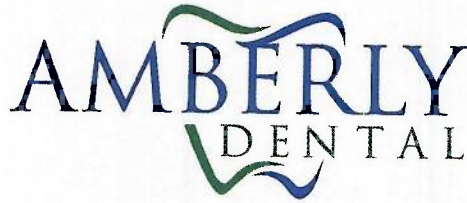
Comments:

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: \_\_\_\_\_



13210 Callum Drive  
Waverly, NE 68462

Phone (402) 786-2007

Fax: (402) 671-7704

**Patient Authorization for Use and Disclosure of Protected Health Information**

By signing, I authorize Amberly Dental to use and/or disclose certain protected health information (PHI) about me to

\_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_.

This authorization permits Amberly Dental to use and/or disclose the following individually identifiable health information about me. The information to be used or disclosed includes but is not limited to: date(s) of services, type of services, all details of services, or origin of information.

The information will be used or disclosed for any purpose deemed necessary by Amberly Dental.

This purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will good until I specifically inform Amberly Dental in writing otherwise.

The Practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

***I do not have to sign this authorization in order to receive treatment from Amberly Dental.***

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **Amberly Dental**

**13210 Callum Dr.  
Waverly, NE 68462**

Signed by: \_\_\_\_\_

Signature of Patient or Legal Guardian

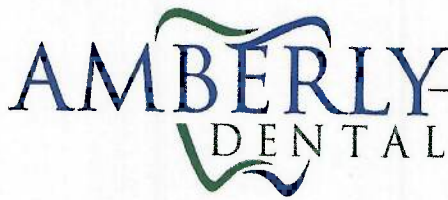
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable





13210 Callum Drive  
Waverly, NE 68462

Phone (402) 786-2007

## Financial Agreement

Payment for services is expected at the time services are provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash and personal checks are accepted along with all major credit cards. If an extended payment plan is desired, please ask about our third party financing options. **PAYMENT ARRANGEMENTS MUST BE MADE PRIOR TO THE START OF YOUR TREATMENT.** Questions can be directed to our treatment coordinator or office manager.

### IF YOU HAVE DENTAL INSURANCE:

Our office participates in PPO programs with Blue Cross/Blue Shield, Delta Dental and Unum insurances. If we are not participating in a PPO program with your dental insurance, as a courtesy we will file your insurance claim for you. We accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance (your out of pocket cost). Our estimates may be different from the insurance company's schedule of "allowable" or "UCR" fees. **THIS IS AN ESTIMATE, SO YOUR FINAL OUT OF POCKET PORTION MAY BE LOWER OR HIGHER.** If you have any questions about this, please feel free to ask. All services rendered are charged directly to the patient, and **THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THEIR ACCOUNT REGARDLESS OF INSURANCE COVERAGE.**

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand that I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due. Should the fees for professional services not be paid in accordance with the provisions herein, reasonable attorney fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due accounts. If the account is in default and turned over for collections, a collection fee may be applied.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date