TRENTON
DENTAL CENTER

WELCOME!

NEW PATIENT REGISTRATION

TODAY'S DATE:_____

FIRST NAME:_____MI:_____LAST NAME:_____

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING ADDRESS):

_____CITY:_____ST:_____ZIP_____

DATE OF BIRTH ___/___/_____ SOCIAL SECURITY #:_____-_____-_____

PHONE #S: HOME(___)_____WORK(___)_____CELL(___)_____

EMAIL ADDRESS:_____

PREFERRED METHOD OF CONTACT: CELL_____HOME_____WORK_____EMAIL_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

NAME:_____

RELATIONSHIP:_____

PHONE #S: HOME (___)_____WORK(___)_____CELL(___)_____

TELL US MORE ABOUT YOU

EMPLOYER_____OCCUPATION_____

IF YOU ARE A STUDENT WHAT SCHOOL DO YOU ATTEND?_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

****IF YOU HAVE DENTAL INSURANCE, PLEASE NOTIFY FRONT DESK****

INSURED MEMBER'S OR RESPONSIBLE PARTY'S INFORMATION

First Name_____MI_____Last Name_____

Address_____City_____ST_____Zip_____

Phone#s:Home(___)_____Cell(___)_____Work(___)_____

Birthdate_____Soc. Sec. #_____

(We MUST have SSN of member to verify and file insurance)

Relationship to Patient_____Phone#_____

Employer_____Ins Company_____

Member ID_____Group #_____

OFFICE POLICIES

PLEASE INITIAL

_____I AGREE TO GIVE A **24 HOUR** NOTICE OF ANY APPOINTMENT I **CANNOT** MAKE OR NEED TO RESCHEDULE OR I WILL BE RESPONSIBLE FOR THE **$60.00 CANCELLATION FEE** AFTER 3 CONSECUTIVE TIMES. (WE REALIZE THAT SOME EVENTS ARE UNFORSEEN AND CANNOT BE AVOIDED)

_____I UNDERSTAND THAT **TRENTON DENTAL CENTER** WILL FILE MY INSURANCE FOR ME AND I WILL EXHAUST ALL EFFORTS TO HAVE MY CLAIM(S) PAID; HOWEVER, I WILL BERESPONSIBLE FOR ANY CHARGES NOT COVERED OR PAID.

Paige Volentine D.D.S.

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?

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:_____

TRENTON
DENTAL CENTER

HIPAA - NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes how health information about you may be used and disclosed and how you can get access to this information. A copy of the Notice of Pamphlet is located at the front desk for you to view and we encourage you to do so. The privacy of your health information is very important us at Trenton Dental Center. We use and disclose health information about you for your treatment, payment, and healthcare operations to a physician or other healthcare providing treatment for you. We must disclose your health information to you, as described in the Patient Right Section of the Notice of Privacy Practices Pamphlet. We may disclose your health information to a family member, friend, or any other person necessary to assist with your healthcare or with payment of your healthcare BUT only if you agree that we may do so.

Please list below the name and relationship of the person(s) other than a healthcare provider you are giving our office the consent to use and disclose your protected health information to carry out treatment, payment activities, and all other healthcare operations. You have the right to revoke this consent at any given time by a giving us a written notice of your revocation.

_____ _____

(authorized person) (relation) (authorized person) (relation)

PATIENT NAME:(please print)_____

PATIENT/PARENT SIGNATURE_____

TODAY'S DATE:_____

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