JESSICA EAGAN DDS
Cosmetic Dentistry | Implant Dentistry | Family Dentistry

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)

Address _____ Address 2 _____
City, St., Zip _____ Birth Date _____
Home Phone _____ Soc. Security _____
Cell Phone _____ Drivers Lic. _____
Work Phone _____ Referred By _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy

Patient Information :: Section 1

Address _____ Address 2 _____
City, St., Zip _____ Birth Date _____
Home Phone _____ Drivers Lic. _____
Cell Phone _____ E-Mail _____
Work Phone _____ Soc. Security _____

Sex ☐ Female ☐ Male Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Primary Insurance Information

Name of Insured _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Social Security _____ Insured Birth Date _____
Employer _____ Insurance Company _____
Employer Address _____ Address _____
City, St., Zip _____ Address 2 _____
Rem. Benefits _____.00 Rem. Deduc _____.00 City, St., Zip _____

Secondary Insurance Information

Name of Insured _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Social Security _____ Insured Birth Date _____
Employer _____ Insurance Company _____
Employer Address _____ Address _____
City, St., Zip _____ Address 2 _____
Rem. Benefits _____.00 Rem. Deduc _____.00 City, St., Zip _____

FEES AND INSURANCE INFORMATION

All fees are payable at the times services are rendered. We accept all major credit cards. Your dental insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charge's is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency, I authorize said attorney to obtain my credit report and I understand that I will be liable for any charges incurred, including reasonable attorney's fees, court costs and collection expenses.

RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Jessica Eagan DDS of all benefits applicable and otherwise payable to me for my insurance carrier or other third party payer, for services rendered by Jessica Eagan DDS. I understand that I am financially responsible for any and all charges that the carrier declines to pay. I hereby authorize release of dental records as deemed necessary for payment of benefits.

Patient's / Guarantor's Signature _____ **Date** _____

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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 many 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 taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphoaphonates? ☐ Yes ☐ No If yes, please explain _____
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
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sicle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain _____

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** _____