PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Preferred Name: _____ **Preferred Pharmacy:** _____

Date of Birth: _____/_____/_____ **Soc. Sec. Number:** _____

Mailing Address: _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Preferred Phone: ☐ Cell ☐ Home ☐ Work **Email Address:** _____

Would you like to sign up for text and/or email appointment reminders? ☐ Text Message ☐ Email

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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐ N/A

RESPONSIBLE PARTY:

Name: _____

Phone Number: _____

Address: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Phone Number: _____

Relationship to patient: _____

PRIMARY DENTAL INSURANCE INFORMATION

If you have a card or a photo of the front and back of your card, please provide it to the receptionist

Policyholder Name: _____ **Date of Birth:** _____/_____/_____

Soc. Sec. Number: _____ **Patient Relationship to Policyholder:** ☐ Self ☐ Spouse ☐ Child

Employer Name: _____

Insurance Company: _____ **Ins. PO Box:** _____

Group Number: _____ **ID Number:** _____

SECONDARY INSURANCE INFORMATION

Policyholder Name: _____ **Date of Birth:** _____/_____/_____

Soc. Sec. Number: _____ **Patient Relationship to Policyholder:** ☐ Self ☐ Spouse ☐ Child

Employer Name: _____

Insurance Company: _____ **Ins. PO Box:** _____

Group Number: _____ **ID Number:** _____

PAYMENT

Charges for services are due and payable at the time of service unless prior arrangements have been made. If you have dental insurance, we will submit your claim. Any remaining balance is patient responsibility.

Patient/Representative Signature: _____ **Date:** _____

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	

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 use controlled substances?	○ Yes ○ No	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	○ 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:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

I acknowledge that I received a copy of John R. McPherson D.D.S.,P.C. Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Dated_____ Patient signature_____

Relationship to Patient _____Print Name_____

Source of Authority_____

John R McPherson DDS PC Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of John R McPherson DDS ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact John R McPherson DDS Privacy Official at:

Record Release Request

John R McPherson D.D.S. P.C.
1255 North 15th St
Laramie Wy 82072

307-742-2328

Date_____

I authorize the release of dental records and dental x rays relevant to dental treatment and request that they be transferred to: mcphersondental@gmail.com

To_____

Address_____

City _____State_____Zip_____

Email Address_____

Print Name of Patient _____

Signature _____