DATE 5/3/2017

TIME 02:00 PM

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

Emergeny Contact Num _____

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: _____

CONWAY FAMILY DENTAL

CONSENT / FINANCIAL POLICY

We make every effort to keep the cost of your dental care to a minimum. Therefore, payment is expected at the time of your visit. Payment may be made by check, cash or credit card. We accept Visa, MasterCard, Discover, American Express and Care Credit.

We are a participating provider with several insurance companies and will file your insurance if you furnish us with all the necessary information. However, you will still be expected to pay your deductible and co-pay at the time of your visit.

In a single parent family or in divorce situations where children are involved, the parent bringing the child to the office for treatment will be responsible for payment.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and that we agree upon. I also understand the use of anesthetic agents embodies a certain risk.

I or we agree to be financially responsible for any unpaid balance due the health care provider for services rendered. I or we grant permission to the health care provider, its agent or assigns to discuss our account and release any information with any third party in order to assist in the payment of any balance due, or otherwise verify personal information provided. Also, it is understood and agreed that the health care provider reserves the right to assess a monthly finance charge, in accordance with Arkansas law, to any unpaid balance due. Further, it is agreed that should the health care provider determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I or we agree to pay any and all collection fees and costs expended to effect recovery, with such collection fees to be 50% of the unpaid balance due. In addition to collection fees, I or we agree to pay attorney fees and court costs should my unpaid account require legal action.

I acknowledge receipt of notice of privacy practices from Conway Family Dental.

Patient Signature_____
(If Minor, Parent or Legal Guardian)

Date _____

Eaglesoft Medical History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or ever had any major operations/surgeries?	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
Have you ever been told by a physician to take antibiotics before a dental appointment?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for osteoporosis?	Yes No	If yes
Are you taking any blood thinners?	Yes No	
Do you use tobacco? Chewing tobacco or Vape?	Yes No	
Do you drink alcohol? If so, how many drinks a day?	Yes No	If yes
Have you ever been told you need to pre-medicate before a dental appointment?	Yes No	If yes

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.

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/Jewelry ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other drugs/materials you are allergic and/or told you should not/cannot take?	Yes No	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 / Fever Blisters	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/STD	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed? Yes No If yes

Dental History

Why have you come to the dentist today?		Comment	
Are you currently in pain?	◯ Yes ◯ No	If yes	
Have you ever had anxiety associated with previous dental work?	◯ Yes ◯ No	If yes	

How would you rate your dental health?

☐ Good ☐ Fair ☐ Poor

Do your gums bleed while flossing or brushing?	◯ Yes ◯ No		
Do you like the appearance of your smile?	◯ Yes ◯ No		
If not, what would you change?		Comment	
How often do you brush?		Comment	
How often do you floss?		Comment	
How often do you use mouthwash?		Comment	
Have you ever experienced pain in your jaws, muscles, ears, or have tension headaches?	◯ Yes ◯ No	If yes	
Are your teeth sensitive to hot/cold, sweets, or biting pressure?	◯ Yes ◯ No	If yes	

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:_____