TIME 8:23 AM

DATE 5/31/2022

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

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 Section 3

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.: _____

GENERIC: _____

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: _____.00 Rem. Deduct: _____.00

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: _____.00 Rem. Deduct: _____.00

Time 9:34 AM

NORTHVIEW DENTAL P.C.

Eaglesoft Medical History(Copy)(Copy)(Copy)(Copy)

Date 2/15/2016

Patient Name: Birth Date: Date Created:

Disclaimer

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

General Single Questions

Are you currently being treated by a physician for a specific heath concern?	○ Yes ○ No	If yes
Are you having any tooth or jaw pain?	○ Yes ○ No	If yes
Have you been diagnosed with sleep apnea? Do you use a CPAP or other treatment?	○ 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	

General List 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	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other allergies?	○ Yes ○ No	If yes
Do you use controlled substances?	☐	If yes
Height		
Weight		

Current Health

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis	☐ Anemia
☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever	☐ Angina
☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism	☐ Arthritis/Gout
☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever	☐ Artificial Heart Valve
☐ Excessive Bleeding	☐ Hives or Rash	☐ Artificial Joint	☐ Excessive Thirst
☐ Hypoglycemia	☐ Sickle Cell Disease	☐ Asthma	☐ Fainting Spells/Dizziness
☐ Irregular Heartbeat	☐ Sinus Trouble	☐ Blood Disease	☐ Frequent Cough
☐ Kidney Problems	☐ Blood Transfusion	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Dry Mouth	☐ GERD/Acid reflux		

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:_____

NORTHVIEW DENTAL

Treatment Consent and Privacy Practices

General Consent to Diagnose and Treat

The undersigned hereby authorizes Northview Dental to take radiographs, models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of their dental conditions and needs. I authorize Northview Dental to perform any and all forms of treatment, medication, and therapy that may be necessary, and further consent that Northview Dental choose and employ such assistance as deemed necessary. I understand that the use of local anesthetic agents embodies certain risk and consent to their use as deemed appropriate by the dental providers. To the best of my knowledge, the questions on my medical history have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my / the patient's health. It is my responsibility to inform Northview Dental of any changes in medical health or status.

Financial Consent

I understand that I am responsible for the payment due for services provided in this office, both for myself and my dependents. Payment is due at time the services are rendered. I understand that I am responsible for any portion of the fees that are not covered by my medical or dental insurance. I consent and acknowledge that I am responsible for any fees necessary (including collections, interest, and attorney's fees) to collect a past due account. If utilizing 3rd party insurance payment, I authorize Northview Dental its employees to verify insurance covered, submit claims, discuss dental treatment with insurance companies, to accept assignment of benefits, and to handle necessary claims appeals.

Northview Dental may contact me via

☐ **Text** ☐ **Email**

Emergency Contact

Name: _____ Phone: _____

Signature Relationship to patient: _____

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to PHI. By signing below you acknowledge receiving notice of our policies and your rights regarding PHI. You also are allowing release of pertinent medical records to my insurance company, other dental or medical providers, and individuals listed here.

Name: _____

Name: _____

Name: _____

Name of Patient: _____ Date: _____

Signature of Patient / Guardian: _____

210 East 91st St, Ste A,
Indianapolis IN 46240

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