

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: _____

Prof. Dentist: _____

Employer ID: _____

Prof. Pharmacy: _____

Carrier ID: _____

Prof. Hyg: _____

Section 3

Spouses Name: _____

Childs Name: _____

Emergency Num: _____

Pharm. Num: _____

Pharmacy Name _____

Fax 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: _____

Erick K. Perroud, D.D.S., P.C.
Eaglesoft Medical History -1B

Patient Name: _____

Birth Date: _____

Date Created: _____

Name and phone of physician(s):	<input type="checkbox"/>	If yes	_____
Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you had a surgery or medical condition that requires you take an antibiotic pre-medication?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you taking any blood thinners?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics

Other Allergies? If yes _____

What was your allergic reaction? 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	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No	COPD	<input type="radio"/> Yes <input type="radio"/> No	ADHD / ADD	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No
Parkinson Disease	<input type="radio"/> Yes <input type="radio"/> 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: _____

DENTAL HISTORY

NAME: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

WHEN WAS YOUR LAST DENTAL VISIT: _____

HOW OFTEN DID YOU VISIT THE DENTIST: _____

PREVIOUS DENTIST NAME & LOCATION: _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN WHEN & WHERE: _____

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____ HOW OFTEN DO YOU FLOSS: _____

IS YOUR DRINKING WATER FLUORIDATED: _____

DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING: YES NO

ARE YOUR TEETH SENS TO SWEET OR SOUR LIQUIDS/FOODS: YES NO

DO YOU FEEL PAIN TO ANY OF YOUR TEETH: YES NO

DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH: YES NO

HAVE YOU EXPERIENCED ANY OF THE FOLLOWIN PROBLEMS IN YOUR JAW?

CLICKING YES NO

PAIN YES NO

DIFFICULTY OPENING/CLOSING YES NO

DIFFICUTLY CHEWING YES NO

DO YOU CLENCH YOUR TEETH: YES NO

DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY: YES NO HAVE YOU EVER HAD A REACTION TO ANESTHESIA: YES NO

HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH: YES NO DO YOU BITE YOUR FINGERNAILS OR OTHER THINGS: YES NO

DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH: YES NO

HAVE YOU EVER HAD PERIODONTAL TREATMENT: YES NO

EVER WORN A BITE SPLINT OR OTHER APPLIANCE: YES NO HAVE YOU EVER HAD ORTHODONTIC CARE: YES NO

HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS: YES NO

HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING AN EXTRACTION: YES NO

DO YOU WEAR PARTIALS OR DENTURES: YES NO

HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS FOR THE CARE OF YOUR TEETH AND GUMS: YES NO

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE: _____

PATIENT SIGNATURE

DATE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

PATIENT NAME _____ **DATE OF BIRTH** _____

I hereby authorize Erick K. Perroud, DDS, PC to release my patient health information as described below:

Name	Relationship	Type of Information to Disclose					Method of Disclosure	
		Treatment	Billing	Appointments	Financial	Insurance	By Phone	In Person
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance and Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of the Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, and the right to revoke and a description of how I may revoke this Authorization is set forth in Erick K. Perroud, DDS, PC's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that Erick K. Perroud, DDS, PC may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

(Check One) I DO _____ I DO NOT _____ GIVE PERMISSION to Erick K. Perroud, DDS, PC, to leave information on my answering machine and / or with family members in regard to treatment plans, referrals, test results and / or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Erick K. Perroud, DDS, PC. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, Erick K. Perroud, DDS, PC will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

Signature of Patient or Personal Representative (i.e. Guardian)

Relationship of Personal Representative to Patient

Date of Authorization _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- *How this office will use and disclose my protected health information.
- *My privacy rights with regard to my protected health information.
- *This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact Dr. Erick Perroud at 231-796-6138. Or I may also contact the Secretary of the U. S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact them.

PATIENT OR PERSONAL REPRESENTATIVE

Signature: _____ Date: _____

Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:
