PATIENT REGISTRATION

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

Preferred Name:

Patient Information:

Address:

City, State, Zip:

Home Phone: **Work Phone:**

Cell Phone: **□ I would like to receive text messages**

Sex:

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: **Drivers Lic#:**

E-mail: **□ I would like to receive email correspondences**

Patient Information (section 2):

Patient/ Parent Employed By: **Present Position:**

How Long Held:

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Spouse/Parent Employed By: **Present Position:**

How Long Held:

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Whom may we thank for this referral?

Primary Insurance Information:

Name of Insured:

Relationship to Insured:

Carrier/ Member/ Subscriber ID:

Insured Birth date:

Employer: **Insurance Company:**

Secondary Insurance Information:

Name of Insured:

Relationship to Insured:

Carrier ID #: **Insured Birth date:**

Employer: **Insurance Company:**

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist use and disclosure of my records or my child's records to carry out treatment, to obtain payment, and for those activity and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following person who are involved in my care (or my child's care) or payment for that care.

_____

My consent to disclosure of records shall be effective until I revoke in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENT'S or GUARDIAN'S SIGNATURE

_____ _____

Signature Date

Financial Agreement

I, _____, assign directly to Dr. Bob Heil, DDS all benefits, otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance. I agree to be financially responsible for services should they be considered "non-covered" or not medically necessary by my insurance company. All fees are due, in full, in advance or at the time of the appointment, regardless of any insurance involvement. Any payment that is not paid is subject to an interest charge of 12% a year.

Payment Options:

1. Cash or Local Checks 24 hours before an appointment 5% Courtesy Credit on most procedures.

2. Credit card (Master card, Visa, or Discover)

3. Third party financing through Care Credit.

4. Invisalign – 5% when paid on the day of patient acceptance.

*New patients are responsible for payment at first appointment.

*Patients with insurance are required to pay their portion at the time of service. Services that require lab work will require payment of half down and half at finish.

*Sedation appointments require payment the day before services are done.

*A Finance Charge of 1% monthly will be applied after 30 days on outstanding balances.

_____ _____

Signature Date

Time 11:17 AM | Oshkosh Complete Dentistry | Date 10/11/2021

Dental History (2)

Patient Name: | Birth Date: | Date Created:

Purpose of your visit / Are you having any issues?

How often do you brush your teeth

How often do you floss?

Have you had any of the following:

Fixed Bridge	Yes	No	Implants	Yes	No	Gum Surgery	Yes	No
Dry Mouth	Yes	No	Wisdom Teeth Removed	Yes	No	Gums Bleed	Yes	No
Braces	Yes	No						

Are your teeth sensitive to:

Hot	Yes	No	Cold	Yes	No
Sweets	Yes	No	Pressure	Yes	No

Have you ever been diagnosed with a problem with either jaw joint?	Yes No	If yes	
Does your jaw click, pop, or make noise when you open or close?	Yes No	If yes	
Do you have tenderness in your jaw when you open, close or chew?	Yes No	If yes	
Has your jaw ever locked open or closed?	Yes No	If yes	
Do you have frequent headaches? If so how often and when?	Yes No	If yes	
Do you have a history of trauma to your jaw?	Yes No	If yes	
Do you clench or grind your teeth, or been told that you do?	Yes No	If yes	

Have you ever had any problem, unpleasant experiences, or complications with previous dental treatment?

How do you feel in general about your teeth? Are there any areas you are unhappy with?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Patient, Parent or Guardian:

X Date:_____

Time 11:15 AM | Oshkosh Complete Dentistry | Date 10/11/2021

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	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	
Do you use controlled substances?	Yes No	If yes

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 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:_____