

**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☐ FemaleMarital 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☐ RetiredStudent Status: ☐ Full Time☐ Part Time

Medicaid ID:

Pref. Dentist:

Employer ID:

Pref. Pharmacy:

Carrier ID:

Pref. Hyg:

## COLLECTIONS

## 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:

## 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

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 above?

☐ 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: \_\_\_\_\_

Alex M. Pentino, DDS  
107 Plaza Drive Suite F  
St. Clairsville, OH 43950

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect \_\_\_\_\_, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.