

# Welcome

## Cold Spring Family Dentistry

### Patient Information (Confidential)

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Home phone # \_\_\_\_\_ Work phone # \_\_\_\_\_ Cell# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female  Married  Single  Divorced  Widowed  Other

If student, name of school/college \_\_\_\_\_ City \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Position \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's name \_\_\_\_\_ Birthdate \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phonebook \_\_\_\_\_ Newspaper \_\_\_\_\_ Other \_\_\_\_\_

Person to contact for emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's medical doctor/clinic \_\_\_\_\_ Phone # \_\_\_\_\_

Closest relative not living with you \_\_\_\_\_ Phone # \_\_\_\_\_

Is another member of your family or relative a patient at our office?  Yes  No Name \_\_\_\_\_

### Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Is person currently a patient of ours?  Yes  No

Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Do you have any other insurance?  Yes  No **When was your last dental visit?** \_\_\_\_\_

### Financial Responsibility

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that .5% finance charge (6% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note.

I authorize insurance payment of dental/medical benefits to Cold Spring Family Dentistry. I authorize Cold Spring Family Dentistry to release any written, verbal, or radiographic dental/medical information requested dental/medical reports and or insurance processing.

Over Please

**COLD SPRING FAMILY DENTISTRY  
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

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

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 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

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

Do you have any problems sleeping or snoring? \_\_\_\_\_

Do you need to take medication prior to Dental work? \_\_\_\_\_

Do you take blood thinners of any kind? \_\_\_\_\_

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: \_\_\_\_\_