TIME 01:39 PM DATE 8/2/2019

# 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: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

### Section 3

## 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:

Time 3:29 PM

Todd W. Fruit, D.M.D.

Date 8/7/2019

# 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, c

| | | |
|---|---|---|
| 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:_____

TODD W. FRUIT, D.M.D.

Neuromuscular • Cosmetic • Restorative • Preventative

Have you had or
do you have:

Headaches Yes No

Facial Pain (Non-specific) Yes No

TMJ Pain Yes No

Tender, Sensitive Teeth
(Percussion) Yes No

TMJ Noise Yes No

Difficulty Chewing Yes No

Limited Opening of the Jaw Yes No

Neck Pain Yes No

Ear Congestion Yes No

Postural Problems Yes No

Vertigo (Dizziness) Yes No

Paresthesia of Fingertips (Tingling) Yes No

Bell's Palsy Yes No

Clinching / Grinding / Bruxing Yes No

Nervousness / Insomnia Yes No

TODD W. FRUIT, D.M.D.
Neuromuscular • Cosmetic • Restorative • Reconstructive

Name:_____

**1: Reservations**

In our office we consider appointments reservations and we reserve time specifically for you. Dr. Fruit and our hygiene team reserve one on one time and prepare the treatment room especially for you; we do not double book time with other patients. Once you have an appointment with our office we consider it confirmed. We don't like to interrupt your day. So, if you would like a courtesy call, let us know and we will be more than happy to contact you the day before your appointment. We do not charge for appointments canceled 48 hours in advance. However, every appointment has costs associated with it. Therefore, after three (3) broken (canceled or no-show) appointments within the 48 hour window, we will require payment in advance for future appointments. _____ - initial

**2: Financials**

To ensure the highest quality of dental services and dental health, Dr. Fruit is not a preferred provider for any insurance plan. Typically insurance plans pay for compromised treatment and hesitate to pay for ideal treatment. Insurance plans are also an agreement between you and your insurer and may not cover all fees for treatment and services provided by Dr. Fruit and his team. **However**, for visits < $300.00 we will file your benefits payable to us and settle any balance due with you after payment is received. Visits > $300.00, please be prepared to pay ½ of the total procedure the day of your visit. The remainder will be filed with insurance. If after 60 days, your benefits have not paid, the balance becomes your responsibility. _____ - initial

**4: Warranty**

Major dental work is covered on a pro-rated scale over 3 years. Warranty is void if the Doctor prescribed maintenance program is not followed. _____ - initial

**5: Consent to Treatment**

I do hereby authorize and request the performance of dental treatment for me by Todd W. Fruit, D.M.D., and any procedures deemed necessary for treatment. I understand Dr. Fruit and his assistant will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics and analgesics deemed advisable.

I understand any treatment plans presented, along with associated fees, may change depending upon time lapse from initial examination and diagnosis and actual treatment rendered date. Once treatment has been started, complications may arise, which dictate additional procedures and/or treatment. Dr. Fruit or the team will always advise me of any changes.

**6: Notice of Privacy Practices and Disclosure of Health Information**

I have been offered a copy of the Notice of Privacy Practices and have had the opportunity to read and consider the contents. This notice provides a description of our treatment, payment activities and healthcare operations, uses and disclosures we may make of your protected health history and information, as well as other important matters about your protected health information.

By signing this consent form, I understand I am giving consent for you to release and disclose my protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

Or Guardian Signature for Minor Patient

**You are entitled to a copy of this consent after signing.**