

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? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco?

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?, Do you use controlled substances?

Do you have, or have you had, any of the following?

AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problems, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed

Comments:

Empty text box for 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:

Signature line with 'X' mark.

Date:

## RODNEY E. SHIVERS, D.D.S.

We would like to welcome you to our office. We are pleased you have chosen us to work with you in maintaining your dental health. If you have any questions regarding this form, please ask our staff for assistance.

Name \_\_\_\_\_  
FIRST MIDDLE INITIAL LAST

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Office # \_\_\_\_\_ Cell # \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_ Contact # \_\_\_\_\_

**\*\*Would you prefer e-mail or text notification of upcoming appointments?  
(Please circle your preference)**

If you prefer e-mail, please list address associated with cell # \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured (if other than patient) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SSN or ID# \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

I assign my dental insurance benefits to Rodney E. Shivers, D.D.S. and authorize release of any necessary dental records to my insurance company to assure payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of parent or guardian if patient is a minor)