Dr. Michael B Jones Inc. Eaglesoft Medical History

Birth Date:

Date Created:

Patient Name:

Although dental person medication that you ma	nel primarily treat y be taking, coul	the area in and a d have an importa	round yount interr	our mou elations	ith, your hip with t	mouth is a part of your the dentistry you will re	entire body. Her ceive. Thank you	alth problems that you may a for answering the following	have, or ng questions.
Are you under a physician's care now?		THE TAX I THE PARTY	⊕ Yes €) No	If yes	***************************************	Commence makes and a commence accommendation	A CONTRACT OF THE PROPERTY OF	
Have you ever been hospitalized or had a major operation?		l a major	⊖ Yes ⊕ No		If yes		-		
Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs?					If yes				
					- •				
		=	-	_	If yes				
Do you take, or have you taken, Phen-Fen or Redux?					If yes		27344		
Have you ever taken Fo any other medications of	samax, Boniva, containing bisph	Actonel or osphonates?) No	If yes				
Are you on a special did			© Yes © No © Yes © No						
Do you use tobacco?		!							
Vomen: Are you	- 1100 -					The second secon			
Pregnant/Trying to g	get pregnant?		Nursing	?		The state of the s	□ Taking o	ral contraceptives?	
re you allergic to any of	the following?								
Aspirin		Penicillin				Codeine Codeine		Acrylic	
Metal Metal		Latex				🗖 Sulfa Drugs		Local Anesthetics	
Other?			<u> </u>		If yes				
Do you use controlled s	uhetaneoe?			, a.					
so you ask controlled s	anstances:		🖰 Yes 🧒) NO	If yes				
you have, or have you	had, any of the	following?				Market of the Company	TO A COMMENT OF THE PARTY OF TH		
AIDS/HIV Positive	O Yes O No	Cortisone Medi	cine	Yes Yes	⊕ No	Hemophilia	🗇 Yes 🔘 No	Radiation Treatments	⊕ Yes ⊕ N
Alzheimer's Disease	🖲 Yes 💮 No	Diabetes		🖰 Yes		Hepatitis A	Yes No	Recent Weight Loss	🖰 Yes 🖱 N
Anaphylaxis	🖒 Yes 🖰 No	Drug Addiction		🖱 Yes	No	Hepatitis B or C	🖱 Yes 🖱 No	Renal Dialysis	O Yes O N
Anemia	🖱 Yes 💮 No	Easily Winded		Yes		Herpes ·	🖱 Yes 🖱 No	Rheumatic Fever	O Yes O N
Angina	🖱 Yes 🖱 No	Emphysema		🖰 Yes	🕑 No	High Blood Pressure	🖰 Yes 🖱 No	Rheumatism	Tes N
Arthritis/Gout	🖱 Yes 🖱 No	Epilepsy or Sei	zures	🖱 Yes	⊘ No	High Cholesterol	🔘 Yes 🕙 No	Scarlet Fever	O Yes O N
Artificial Heart Valve	🖒 Yes 🕙 No	Excessive Bleed	ling	🖱 Yes	⊕ No	Hives or Rash	O Yes O No	Shingles	🖰 Yes 🗑 N
Artificial Joint	🖰 Yes 🖰 No	Excessive Thirs	t	🖰 Yes	O No	Hypoglycemia	Yes 🕅 No	Sickle Cell Disease	⊕ Yes ⊕ N
Asthma	🔿 Yes 🕙 No	Fainting Spells/D	izziness	🖱 Yes	⊗ No	Irregular Heartbeat	⊕ Yes ⊕ No	Sinus Trouble	⊕ Yes ⊕ N
Blood Disease	🖲 Yes 🗑 No	Frequent Cougi	h	🖱 Yes		Kidney Problems	⊕ Yes ⊕ No	Spina Bifida	⊕ Yes ⊕ N
Blood Transfusion	🖰 Yes 🖰 No	Frequent Diarri	nea	🖱 Yes	⊘ No	Leukemia	Yes No	Stomach/Intestinal Disease	⊕ Yes ⊕ N
Breathing Problems	🖱 Yes 🖱 No	Frequent Heads	ches	🖱 Yes	No No	Liver Disease	Yes No	Stroke	⊕ Yes ⊕ N
Bruise Eastly	O Yes O No	Genital Herpes		Tes	⊕ No ·	Low Blood Pressure	⊕ Yes ⊕ No	Swelling of Limbs	O Yes O N
Cancer	🖰 Yes 🖰 No	Glaucoma		O Yes		Lung Disease	© Yes ⊕ No	· ·	
Chemotherapy	🗘 Yes 🖔 No	Hay Fever		O Yes	-	Mitral Valve Prolapse	O Yes O No	Thyroid Disease Tonsillitis	O Yes O N
Chest Pains	🖱 Yes 🖱 No	Heart Attack/Fa		Yes		Osteoporosis	© Yes © No	Tuberculosis	O Yes O N
Cold Sores/Fever Blisters		Heart Murmur		Ø Yes		Pain in Jaw Joints	© Yes @ No	1	© Yes © N
	O Yes O No	Heart Pacemak		© Yes		Parathyroid Disease	② Yes ② No	Tumors or Growths	O Yes O N
Convulsions	O Yes O No	Heart Trouble/			_	Psychiatric Care	© Yes ⊘ No	Vicers	O Yes O No
	_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 Sychiad IC Care	C 103 O 110	Venereal Disease Yellow Jaundice	⊕ Yes ⊕ No
lave you ever had any s	serious illness n	ot listed) Yes (No	If yes			1	

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:
	Date

PATIENT REGISTRATION

ID:	Chart ID:				
First Name:		Last Name:			Middle Initial:
Patient Is: Policy Hol		Preferred Name:			
Responsible Party (if someone other than the patient)			· · · · · · · · · · · · · · · · · · ·	
First Name:		Last Name:			Middle Initial:
Address:		Address			- Company of Anna Company of Comp
City, State, Zin:		*	- Profession of the sense of meetings place, sense apple decings and	till det sekreta til till til sekreta og sekrat fra år frem siderat sek kappa k	Pager:
Home Phone:	Work Phon	3.		Ext:	Cellular:
Birth Date:	Soc Se	: :		Drivers I	ic.
Pagnongible Bosts in all	mids on white and an arrangement of the second	ACCESSES, CARRIED & Management of Access of the Access of			
Responsible Party is als	so a Policy Holder for Patient	Primary Insurance	Policy Holder	Sec	ondary Insurance Policy Holder
Patient Information					
Address:		Address	2:		
City:	The second secon	State / Zip:			Pager:
Home Phone:	Work Phone			Ext:	Cellular:
Sex: Male	Female	Marital Status: N	Married Single	Divorced [Separated Widowed
Birth Date:	Age	: Soc S	Sec:	Drivers L	ic:
E-mail:	The second secon		would like to receive	correspondences via e	-mail.
	— Section 2 ———				Section 3
Employment Full Status:	Time Part Time	Retired	·		
Student Status: Full	Time Part Time				
Medicaid ID:	Pref. De	entist:			
Employer ID:	Pref. Phar	nacy:			
Carrier ID:	Pref.	Hyg:			
Primary Insurance In	formation —				
Name of Insured:	•		Relationship to Ins	ured: Self	Spouse Child Other
Insured Soc. Sec:	To the common distribution on the property to the Market of the Common destroy of the Common of the Market of the Common of the	Insured Birth Da			
Employer:			Ins. Compar	ny:	Control of the Contro
Address:		To the second party of the	Addre		
Address 2:			Address	2:	
City, State, Zip:			City, State, Z	ip:	
Rem. Benefits:		m. Deduct:			
Secondary Insurance	Information —				
Name of Insured:			Relationship to Ins	ured Self	Spouse Child Other
Insured Soc. Sec:		Insured Birth Da	-		Spouse Clemin Conici
Employer:			Ins. Compar	iy:	en e
Address:	THE RESERVE OF THE PROPERTY WHEN THE PROPERTY OF THE PROPERTY		Addre		A desired of the constraint of
Address 2:	THE PERSON NAMED OF THE PE		Address		
City, State, Zip:			City, State, Zi		
Rem. Benefits:	Re	m. Deduct:		·	
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