Today's Date: _____

Patient Information:

First Name:_____ Last Name:_____

Date of Birth:_____ Social Security Number:_____

Emergency Contact Name:_____ Phone Number: _____

Responsible Party Information:

First Name:_____ Last Name:_____ Employer:_____

Date of Birth:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone:_____

Work Phone:_____ Email Address:_____

Insurance Information:

Company Name:_____ Member ID #:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Policy Holder Social Security Number:_____ Employer:_____

*If you have secondary insurance please notify the front desk

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Signature_____ Date:_____

Acknowledgement of Receipt of Privacy Practices

I,_____ understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPPA). I understand that by signing this consent;

I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (i.e. my insurance company) and for the day to day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your notice of privacy practices which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions, however, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name:_____ Signature_____ Date_____

Relationship to the patient if under 18 or unable to sign _____

Acknowledgement of Receipt of Financial Responsibility

I certify that I, and/or my dependent have insurance coverage with _____ (name of insurance company), and assign directly to Rubicon Dental Associates all insurance benefits (if any). I understand that I am financially responsible for all charges whether or not they are paid by insurance.

I understand that if I do not have an insurance carrier that I am responsible for the balance on the account at the time the charges are incurred. I also understand that if I do not pay my balance that finance charges will be added onto my balance after 30 days.

Print Name:_____ Signature_____ Date_____

Time 3:36 PM | Rubicon Dental Associates | Date 12/12/2018

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:_____