Eugene Dental Group

PATIENT REGISTRATION

Patient's Full Name _____ **Nickname** _____

DOB _____ **Marital Status**: _____ **Sex**: □ M □ F □ Other

Mailing Address (Single / Married / Divorced / Widowed / Child)

Street _____ City _____ State ____ ZIP _____

Contact Number: Home _____ Cell _____ Work _____

Preferred Confirmation Method: □ Text □ Email □ Phone Call Only

Email _____ **Social Security Number** _____

Employer _____ **Occupation** _____

How Did You Hear About Our Office? _____

Responsible Party (Spouse/Parent)

Name _____ **Relationship** _____ **Number** _____

Address (If different from above) _____

Emergency Contact: **Name**_____ **Number** _____

Authorization and Release: I certify that the above information is accurate to my knowledge. I hereby authorize Eugene Dental Group to administer treatment, x-rays, anesthetics, and to perform dental procedures as deemed necessary or advisable in the diagnosis and treatment of my dental condition**. I acknowledge that I am responsible for all cost of treatment, deductible, insurance copayments, and other balances due at time of service.** I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to this practice. I understand it is my responsibility to notify changes to my account. If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. **If unable to keep an appointment, kindly give 48 hours' notice.**

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

MEDICAL HISTORY

Under Physician Care? ☐Y ☐N Name of Physician: _____

Been hospitalized or had major operation? ☐Y ☐N Reason: _____

Had a serious head or neck injury? ☐Y ☐N Type of injury: _____

Taking/Taken Phen –Fen or Redux? ☐Y ☐N

Taking/Taken Fosamax, Bonva, Actonel, or meds that contain Bisphosphonates? ☐Y ☐N
Reason: _____

Take antibiotics prior to dental treatment? ☐Y ☐N Reason: _____

Do you use? (Please check all that apply) ☐ Routine Aspirin ☐ Blood Thinners

☐ Tobacco ☐ Alcohol ☐ Special Diet ☐ Controlled Substances, Type: _____

Women are you? ☐ Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Allergies: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Latex ☐ Local Anesthetics

☐ Acrylic Metal ☐ Other(s) _____

Medication List (List all prescription, non-prescription, & herbal products. Use back for additional space)

Medication	Dosage	Frequency	Condition

Do you have, or 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 Problem
- ☐ 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 Pace Maker
- ☐ 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 had a serious illness not listed above, if so please explain: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that not providing 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 _____ DATE _____

Acknowledgement of the Notice of Privacy Practices **(HIPAA)**

I acknowledge that by request I can obtain a copy of the Notice of Privacy Practices of Eugene Dental Group. I hereby authorize, as indicated by my signature below, to use and to disclose my Protected Health Information (PHI) for any necessary clinical, financial and insurance purposes as authorized in the patient consent form.

Patient Name: _____

Authorized Persons: Please list authorized persons with whom we may discuss your PHI in addition to custodial parents and legal guardians.

Name: _____ Relationship: _____ Effective Until: _____

Name: _____ Relationship: _____ Effective Until: _____

Name: _____ Relationship: _____ Effective Until: _____

Name: _____ Relationship: _____ Effective Until: _____

Name: _____ Relationship: _____ Effective Until: _____

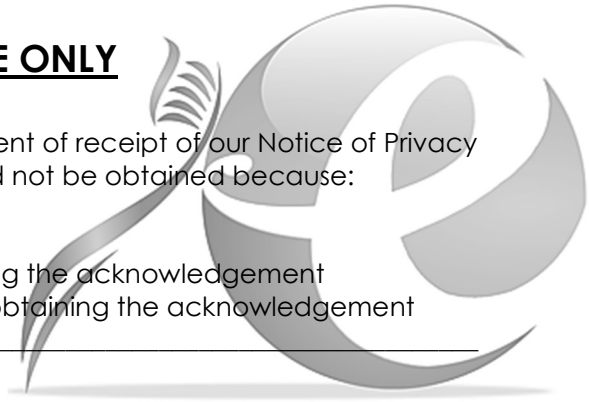
I hereby authorize Eugene Dental Group to send correspondence and x-rays to a specialist via fax or email in a secure format.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining the acknowledgement
- □ Other (Please Specify) _____
- □ Staff initials: _____



EUGENE DENTAL GROUP

▪ Dr. Elizabeth Vivona ▪ Dr. Melanie Rawlings ▪

DENTAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____ **Phone Number:** _____

Additional Family Members

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Previous Dental Information

Previous Dentist: _____ Clinic Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

Email: _____

I hereby give permission to release any and all of my dental records to Eugene Dental Group.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

Please forward any x-rays, probing depth charts, and photographs to our office with the information below. Email is preferred.

Email: office@eugenedentalgroup.com
Fax: 541-686-3334
Mailing Address:
Eugene Dental Group
4750 Village Plaza Loop Ste 200
Eugene, OR. 97401.

EUGENE DENTAL GROUP

▪ Dr. Elizabeth Vivona ▪ Dr. Melanie Rawlings ▪