

# 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

### Section 3

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: \_\_\_\_\_  
Emergency Contact Medical Doctor: \_\_\_\_\_

## 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: \_\_\_\_\_

Brian L. Biehl, LLC  
Eaglesoft Medical History (Copy)

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: \_\_\_\_\_

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

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

Do you use controlled substances?  Yes  No If yes: \_\_\_\_\_

Other?  If yes: \_\_\_\_\_

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

|  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems <input type="radio"/> Yes <input type="radio"/> No        | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No           |  |  |   |

Have you ever had any serious illness not listed  Yes  No If yes: \_\_\_\_\_

**Dental History**

Please indicate any of the following problems:

|  |  |  |  |
|--|--|--|--|
| Discomfort, clicking, or popping in jaw <input type="radio"/> Yes <input type="radio"/> No | Sensitive tooth, teeth, or gums <input type="radio"/> Yes <input type="radio"/> No | Blisters/Sores in or around the mouth <input type="radio"/> Yes <input type="radio"/> No | Lost/Broken filling(s) <input type="radio"/> Yes <input type="radio"/> No        |
| Bad breath <input type="radio"/> Yes <input type="radio"/> No                              | Stained teeth <input type="radio"/> Yes <input type="radio"/> No                   | Locking jaw <input type="radio"/> Yes <input type="radio"/> No                           | Do You Require Pre-Medication <input type="radio"/> Yes <input type="radio"/> No |
| Red, swollen, or bleeding gums <input type="radio"/> Yes <input type="radio"/> No          | Broken/Chipped tooth <input type="radio"/> Yes <input type="radio"/> No            | Teeth grinding <input type="radio"/> Yes <input type="radio"/> No                        |  |

Previous Dentist: \_\_\_\_\_

Last Dental Exam: \_\_\_\_\_

Date of Last Dental Xrays: \_\_\_\_\_

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: \_\_\_\_\_

FINANCIAL POLICY

BRIAN L. BIEHL, DMD

EFFECTIVE 11/1/2001

Dear Patient:

Thank you for choosing us as your dental care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask.

We require that all patients read and sign our Financial Policy as well as complete a Patient Information Sheet and Health History Form prior to seeing the doctor.

**If you do not have insurance** all payment for services rendered are due at the time of your visit.

We accept cash, checks, Mastercard, Visa, American Express, and Discover. We also have a monthly payment using Care Credit. This is processed through the Care Credit Company. An application must be filled out and we will process it immediately. Please ask for more details if interested.

**If you do have insurance** we will be happy to file the insurance for you as long as you provide COMPLETE insurance information. You will be responsible for any deductibles or co payments at the time of you visit. However, you must understand that,

Your insurance is a contract between you, your employer, and the Insurance Company. We are not party to that contract. Our relationship is with you, not your insurance company.

**ALL CHARGES ARE YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT.** Not all services covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Accounts over 90 days unpaid will be placed with a collection agency. Collection agency fees will be added to your final balance at the open legal rate of interest. You will be responsible for these additional charges.

---

PRINT NAME

SIGNATURE

DATE

Dr. Brian Biehl

Acknowledgement of Receipt of  
Notice of Privacy Practices

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

---

Please Print Name

---

Signature

---

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

\_\_\_ Communication barriers prohibited obtaining the acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgment