VANDERLUGT and MULDER DENTAL, PLLC

PATIENT REGISTRATION

First Name_____ Last Name:_____Middle Initial:_____ Male___ Female___

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

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Birthdate:_____ Soc Security:_____ Email Address_____

Check appropriate box ___Minor ___Single ___Married ___Divorced ___Widowed___Separated

Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account_____Relationship to Patient _____

Address_____Home Phone _____

Driver's License #_____ Birthdate_____SS#_____

Employer_____Work Phone_____

Is this person currently a patient in our office? ___YES___NO

Insurance Information

Name of Insured_____Relationship to Patient _____

Birthdate_____ SS#_____ Date Employed _____

Name of Employer_____Union or Local#_____ Work Phone _____

Employer Address_____ City_____ State_____ Zip _____

Insurance Co._____ Tel# _____

In. Co. Address_____ City_____State_____Zip_____

I.D #_____ GRP #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE ___YES ___NO IF YES, COMPLETE THE FOLLOWING

Name of Insured_____Relationship to Patient _____

Birthdate_____ SS#_____ Date Employed _____

Name of Employer_____Union or Local#_____ Work Phone _____

Employer Address_____ City_____ State_____ Zip _____

Insurance Co._____ Tel# _____

In. Co. Address_____ City_____State_____Zip_____

I.D #_____ GRP #_____

X_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

VANDERLUGT and MULDER DENTAL, PLLC

Patient's Dental History

Patient's Name_____ Date of Birth _____

Previous Dentist Name_____ Location _____

When was your last dental visit?_____

Have you had a complete series of dental x-rays taken?_____ Where and When _____

Do your gums bleed while brushing or flossing?_____Do you have jaw pain or clicking? _____

Do you clench or grind your teeth?_____ Does food get caught between your teeth? _____

Have you ever had periodontal treatment (gums)?_____If yes where/when _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date _____

Signature of patient or parent/guardian if minor

Patient Authorization to Release Protected Health info to third parties

By signing this authorization, I authorize VanderLugt and Mulder Dental, PLLC to use and/or disclose certain protected dental information about me to or for the party or parties listed below. This authorization permits VanderLugt and Mulder Dental, PLLC to use or disclose individually identifiable health information to the following persons:

Please check all that apply: Spouse☐ Parents☐ All family members☐ Other(s): _____

(Please List)

This authorization will expire on:_____ Or check Indefinitely ☐

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that VanderLugt and Mulder Dental, PLLC has acted in reliance upon this authorization. My written revocation must be submitted to VanderLugt and Mulder Dental, PLLC, Attn: Administrator, at 2008 Eastcastle Dr. SE, Suite C, Grand Rapids, MI 49508.

Signed by: _____ _____

Signature of patient or Legal Guardian Date

_____

Print Patient's Name

_____

Print Name of Legal Guardian

VANDERLUGT and MULDER DENTAL, PLLC

VanderLugt And Mulder Dental PLLC

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	

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 use controlled substances?	◯ Yes ◯ No	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 ◯ 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:_____