PATIENT REGISTRATION		
ID: Chart ID:		
First Name: Last Name	e: Middle Initial:	
Patient Is: Policy Holder Responsible Party Preferred Name	e:	
Responsible Party (if someone other than the patient)		
First Name: Last Nam	e: Middle Initial:	
Address: A	ddress 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 Insu	rance Policy Holder Secondary Insurance Policy Holder	
Patient Information		
Address: A	ddress 2:	
City: State / Zi	p: Pager:	
Home Phone: Work Phone:	Ext: Cellular:	
Sex: Male Female Marital Statu	s: 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 Full Time Part Time Retired	Emergency Contact	
Student Status: Full Time Part Time		
Medicaid ID: Pref. Dentist:		
Employer ID: Pref. Pharmacy:		
Carrier ID: Pref. Hyg:		
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:		

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Eaglesoft Medical History Birth Date: Date Created

Although dental personnel premarily 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 have you were been hospitalized or had a major operation? Yes
Have you ever been hospitalized or had a major operation? Yes No 1f yes Have you ever had a serious head or neck injury? Yes No 1f yes Do you take, or have you taken, Phen-Fao or Redux? Yes No 1f yes Have you ever taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Have you over taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Have you over taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Have you over taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Do you use tobacco? Yes No 1f yes Do you use controlled substances? Yes No 1f yes Well No No Yes No 1f yes Well No No Yes No Yes No Yes No Yes No Alphalmar's Disease Yes No Diabetes Yes No Hepatitis A Yes No Readiation Treatments Angina Yes No Ebilappy or Seizures Yes No Hepatitis B or C Yes No Readiation Arthritis/Gout Yes No Ebilappy or Seizures Yes No High Cholesterol Yes No Reduited Yes No Arthritis/Gout Yes No Ebilappy or Seizures Yes No Hypoglycens Yes No Singles Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycens Yes No Singles Arthritis/Gout Yes No Frequent Cough Yes No Kidney Problems Yes No Singles No Singles Yes No Singles No No No No No No No N
Have you ever been hospitalized or had a major operation? Yes No 1f yes Have you ever had a serious head or neck injury? Yes No 1f yes Do you take, or have you taken, Phen-Fao or Redux? Yes No 1f yes Have you ever taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Have you over taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Have you over taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Have you over taken Fosamas, Boniva, Actonel or any other Yes No 1f yes Do you use tobacco? Yes No 1f yes Do you use controlled substances? Yes No 1f yes Well No No Yes No 1f yes Well No No Yes No Yes No Yes No Yes No Alphalmar's Disease Yes No Diabetes Yes No Hepatitis A Yes No Readiation Treatments Angina Yes No Ebilappy or Seizures Yes No Hepatitis B or C Yes No Readiation Arthritis/Gout Yes No Ebilappy or Seizures Yes No High Cholesterol Yes No Reduited Yes No Arthritis/Gout Yes No Ebilappy or Seizures Yes No Hypoglycens Yes No Singles Arthritis/Gout Yes No Excessive Bleeding Yes No Hypoglycens Yes No Singles Arthritis/Gout Yes No Frequent Cough Yes No Kidney Problems Yes No Singles No Singles Yes No Singles No No No No No No No N
Are you ever had a serious head or neck injury? Yes No 1f yes Are you taking any medications, pills, or drugs? Yes No 1f yes Do you take, or have you takan, Phen-Fin or Redux? Yes No 1f yes Have you ever taken Fooamas, Boniva, Actorel or any other Yes No 1f yes Are you on a special diet? Yes No 1f yes Do you use tobacco? Yes No 1f yes Do you use controlled substances? Yes No 1f yes Do you use controlled substances? Yes No 1f yes Omen: Are you Pregnant/Trying to get pregnant? Penicillin Codeine Acrylic Aspirin Penicillin Cadeine Acrylic Aspirin Penicillin Codeine Acry
Are you taking any medications, pills, or drugs? Or you take, or have you taken, Phen-Fen or Redux? Yes No If yes Have you over taken Fosamax, Boniva, Actorel or any other medications containing bisphosphondes? Are you on a special diet? Yes No If yes Do you use controlled substances? Yes No If yes Omer: Are you. Pregnant/Trying to get pregnant? Nursing? Penicillin Codeine Acrylic Aspiris Penicillin Latex Sulfa Drugs Codeine Acrylic Local Anesthetics Other? If yes Other ADS/HTV Positive Yes No Cortisone Medicine Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylas Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylas Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylass Yes No Essily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Artificial Joiet Yes No Emphysema Yes No High Cholesterol Yes No Scarlet Fever Artificial Joiet Yes No Fainting Spoiliars Yes No Frequent Diarnes Prequent Clough Yes No Lewkenia Yes No Singles Blood Transfusion Yes No Genital Herpes Yes No Comercian Artificial Disease Breathing Problems Briss Easily Yes No Genital Herpes Yes No Comercian Artificial Disease Yes No Comercian Artifici
Do you take, or have you taken, Phen-Fen or Reduc? Yes No 1F yes Have you ever taken Fosamax, Boniva, Actonel or any other Yes No 1F yes No Types Do you use tobacco? Yes No Or you use controlled substances? Yes No Or you use controlled substances? No No No No No No No No No N
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphoredse? Ves No Ves
Are you on a special diet? Or you use tobacco? Or yes No If yes Or you use tobacco? Or yes No If yes Or you use controlled substances? Pregnant/Trying to get pregnant? Nursing? If yes Or you use tobacco? Or you use controlled substances? Pregnant/Trying to get pregnant? Nursing? If yes Or you share, or have you had, any of the following? Albeimer's Disease Yes No Orisone Medidne Orisone Medidne Yes No Hemophilia Altheimer's Disease Yes No Orisone Medidne Orisone Medidne Orisone Medidne Orisone Medidne Yes No Hemophilia Heatitis B or C Yes No Radiation Treatments Anaphylaws Anaphylaws Anaphylaws Yes No Herpettis B or C Yes No Renal Dilays Anaphylaws Anaphylaws Anaphylaws Yes No Essily Winded Yes No Herpettis B or C Yes No Renal Dilays Anaphylaws Anaphylaws Anaphylaws Yes No Esphysema Yes No High Cholesterol Yes No Rheumatism Arthritis/Gout Yes No Excessive Bileading Yes No Hives or Rash Yes No Scarlet Fever Artificial Joiet Yes No Excessive Bileading Yes No Hypoglycemia Yes No Sining Biload Arthritis/ Brother Yes No Sining Biload Yes No Sining Biload Yes No Sining Biload No Somach/Zhitestinal Disease Brathing Problems Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Swelling of Limbs Orionach/Zhitestinal Disease Brathing Problems Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Orionach/Zhitestinal Disease Broad Frequent Dlarnhea Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Orionach/Zhitestinal Disease No Swelling of Limbs Orionach/Zhitestinal Disease No Swelling of Limbs
Do you use tobacco? Yes No If yes One you use controlled substances? Yes No If yes Onemen: Are you Pregnant/Trying to get pregnant? Nursing? Penicillin Codeine Acaptire Metal Latex Sulfa Drugs Local Anesthetics Other? If yes Other? ADS/N1V Positive Yes No Diabetes Yes No Diabetes Yes No Drug Addiction Yes No Hepatitis A Yes No Recent Weight Local Anaphylaxas Anaphylaxas Yes No Essity Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Anaphylaxas Yes No Emphysema Yes No Ephphysema Yes No Hepatitis B or C Yes No Remal Dialysis Anthritic/locat Arthritic/locat Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Schrief Ever Artificial Joint Yes No Fainting Spells/Dizzness Yes No Hepatitis Yes No Schrief Ever High Cholesterol Yes No Schrief Ever Artificial Joint Yes No Frequent Cough Yes No Hergular Heartbeat Yes No Schrief Ever No Schrief
Organication of the following? Pregnant/Trying to get pregnant?
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?
Pregnant/Trying to get pregnant? Nursing? Taking or al contraceptives?
e you allergic to any of the following? Apprim
Aspirin
Metal Latex Sulfa Drugs Local Anesthetics
Dither?
Typo have, or have you had, any of the following? AIDS/HIV Positive
AlDs(MIV Positive Ves No Radiation Treatments O Alzheimer's Disease Ves No Diabetes Ves No Diabetes Ves No Diabetes Ves No Drug Addiction Ves No Hepatitis A Ves No Recent Weight Loss Anaphylaxis Ves No Easily Winded Ves No Easily Winded Ves No Hepatitis B or C Ves No Renal Dialysis Anaphylaxis Ves No Emphysema Ves No Emphysema Ves No High Blood Pressure Ves No Remai Dialysis No Arthritis/Gout Ves No Epilepsy or Seizures Ves No High Cholesterol Ves No Scarlet Fever Artificial Heart Valve Ves No Excessive Bleeding Ves No Hives or Rash Ves No Singles Artificial Joint Ves No Excessive Thirst Ves No Hypoglycemia Ves No Singles Ves No Single Cell Disease Artificial Joint Ves No Fequent Cough Ves No Erequent Diarrhea Ves No Erequent Diarrhea Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Heart Disease Ves No Erequent Disease Ves No Erequent Disease Ves No Erequent Disease Ves No Ereq
Alzheimer's Disease
Anaphylaxis
Angina Ves No Emphysema Ves No High Blood Pressure Ves No Rheumatic Fever Angina Ves No Emphysema Ves No High Blood Pressure Ves No Rheumatism Arthritis/Gout Ves No Epilepsy or Seizures Ves No High Cholesterol Ves No Scarlet Fever Artificial Heart Valve Ves No Excessive Bleeding Ves No High Cholesterol Ves No Scarlet Fever Artificial Joint Ves No Excessive Thirst Ves No Hypoglyceria Ves No Singles Artificial Joint Ves No Fainting Spellis/Dizzness Ves No Irregular Heartbeat Ves No Sinus Trouble Sinus Trouble Sinus Trouble Sinus Trouble Ves No Frequent Cough Ves No Kidney Problems Ves No Scarlet Fever No Sinus Trouble Sinus Tr
Angina
Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Singles Artificial Joint Yes No Excessive Thirst Yes No Hypoglycenia Yes No Singles Artificial Joint Yes No Fainting Spells/Dizziness Yes No Hives or Rash Yes No Singles No No No Singles No
Artificial Heart Valve
Artificial Joint Ves No Excessive Thirst Ves No Hypoglycenia Ves No Sickle Cell Disease Asthma Ves No Fainting Spells/Dizzness Ves No Irregular Heartbeat Ves No Sinus Trouble Blood Disease Ves No Frequent Cough Ves No Kidney Problems Ves No Spina Bifida Blood Transfusion Ves No Frequent Diarrhea Ves No Leukemia Ves No Stomach/Intestinal Disease Breathing Problems Ves No Genital Herpes Ves No Low Blood Pressure Ves No Swelling of Limbs Bruise Easily Ves No Genital Herpes Ves No Low Blood Pressure Ves No Swelling of Limbs
Ashtma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily O Yes O No Genital Herpes O Yes O No Low Blood Pressure O Yes O No Swelling of Limbs
Chemotherapy O Yes O No Hay Fever O Yes O No Mitral Valve Prolapse O Yes O No Tonsillitis
Chest Pains O Yes O No Heart Attack/Failure O Yes O No Osteoporosis O Yes O No Tuberculosis O
Cold Sores/Fever Blisters () Yes () No Heart Murmur () Yes () No Pain in Jaw Joints () Yes () No Tumors or Growths ()
Congenital Heart Disorder () Yes () No Heart Pacemaker () Yes () No Parathyroid Disease () Yes () No Ulcers
Convulsions
YellowJaundice
lave you ever had any serious illness not listed above? O Yes O No If yes
omments:
Comments:

Dental History Form		
Patient Name:	_ Date of Birth	
At-Home Oral Hygiene Care How often do you brush your teeth? How often do you floss? Do you use mouthwash? Yes/No if yes, what kind Do you use any other dental home care products? Yes		
Circle Appropriate Answer		
 Are you currently experiencing dental pain or districted life yes, explain: Do your gums bleed? Yes/No Are your teeth loose? Yes/No Do you wear dentures or partials? Yes/No Have you ever been told you have gum disease? Are your teeth sensitive to hot, cold, sweets or p Have you ever had any clicking, popping or disco Do you brux or grind your teeth? Yes/No Do you wear an occlusal guard? Yes/No Have you ever had orthodontic treatment (brace Do you have dry mouth? Yes/No Does food or floss catch between your teeth? Ye Have you had any problems or an upsetting dent Yes/No if yes, explain: Are you fearful of dentistry or have anxiety assoc Have you ever been pre-medicated for dental tree Have you ever had a reaction to anesthetic used Are you happy with your smile? Yes/No What would you change about the present cond 	Yes/No ressure? Yes/No mfort in the jaw? Yes/No s/No al experience associated with previous dental care? ciated with dental treatment? Yes/No retment? Yes/No with your dental treatment? Yes/No	
19. Is there anything else you would like us to know if yes, explain:	·	
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and her staff will rely on this information for treating me. Signature of Patient/Parent/Guardian:		

Kemp Family Dental LLC

Consent for use and Disclosure of Health Information

Section A: Patient giving consent Name Address Telephone _____ E-Mail_____ Social Security Number__ Section B: To the Patient-Please Read the following statements carefully. Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Contact Person: Dr. Erin Kemp Telephone: <u>614-882-7555</u> Fax: <u>614-882-0738</u> Email: <u>Dentists@KempFamilyDental.com</u> Address: 509 South Otterbein Avenue Westerville Ohio 43081 Right to Revoke: You will have to right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. _____ have had full opportunity to read and consider the contents of this Consent form and you Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent of your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. If this Consent is signed by a personal representative on behalf of the patient, complete the following: Personal Representative's Name: Relationship to Patient: You are entitled to a copy of this consent after you sign it. Include completed Consent in the patient's chart REVOCATION OF CONSENT I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent

_Date___