**Graham Family Dental**
**325 W. Main St. Suite G**
**Riverton, WY 82501**

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. My account will be charged 1% (minimum fee of $1.50) per month finance charge on balances after 30 days.

I understand and agree that I will show up for my appointed time. If I do not give 24-hour notice there will be a $25.00 fee applied to my account, and I will be responsible to pay that in full before the next appointment is scheduled. I understand that there is a 3-strike policy that states that if I miss 3 appointments I will be dismissed from the practice.

All information I have provided Graham Family Dental is correct to the best of my knowledge. I will notify you of any changes in my health status, insurance carrier, phone #, address or any other information to be updated in our records.

I acknowledge that I have been provided the Graham Family Dental notice of Privacy Practice.

My signature on this form gives this office permission to release information to my insurance company and for the insurance company to pay this office directly.

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse, and information about mental health services) under the following terms:

Detailed description of the information to be released:

To whom may the information be released (name(s) or class(es) of recipients):

The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We can refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon your authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorizations, including, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I consent to the dental practice using my cell phone number to call/text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. However, I will provide a contact number if I opt to withdraw my consent.

I have read and understand this form. I am signing I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

If you sign as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Patient Signature_____Date_____

Patient Name: _____

## Graham Family Dental

## 325 West Main Street Suite G

## Riverton, WY 82501

Male_____ Female_____ SS#_____Date of Birth_____

Name_____Phone (H)_____(C)_____

Preferred Name_____ Preferred communication (Text) (Phone) (Email)

Drivers License#_____Email_____

Mailing Address_____City_____State_____Zip_____

Employer_____Business Address_____Phone_____

Spouses Name_____Phone (H)_____(C)_____

Employer_____Business Address_____Phone_____

**If Minor:**

Fathers Name_____Phone (H)_____(C)_____

Mailing Address_____City_____State_____Zip_____

Employer_____Business Address_____Phone_____

Mothers Name_____Phone (H)_____(C)_____

Mailing Address_____City_____State_____Zip_____

Employer_____Business Address_____Phone_____

**Insurance:**

Policy Holders Name_____ Date of Birth_____SS#_____

Employers Name and Address_____

Insurance Company_____Policy #_____Group#_____

Physician_____City_____Phone_____

Pervious Dentist_____City_____Phone_____

**Preferred Pharmacy**_____Phone_____

**Emergency Contact**_____Phone_____

Who may we thank for referring you to our office_____

I will be paying today with Cash_____Check_____Credit Card_____

Graham Family Dental

# 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:_____