Time 3:34 PM

Chamberlain Family Dentistry

Date 2/11/2026

# 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, c

| | | |
|---|---|---|
| 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: _____

# CHAMBERLAIN FAMILY DENTISTRY

## *PATIENT REGISTRATION*

**Patient Information:**

| | | |
|---|---|---|
| First Name: | Last Name: | Middle Initial: |
| Preferred Name: | Sex: ○ Female ○ Male | |
| Mailing Address: | City/State: | Zip: |
| Physical Address: | City/State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: |
| Birth date: | Social Security #: | E-mail: |
| Emergency Contact: | Emergency Phone Number: | |

**Responsible Party:** (if someone other than the patient)

| | | |
|---|---|---|
| First Name: | Last Name: | Birth date: |
| Mailing Address: | City/State: | Zip: |
| Physical Address: | City/State: | Zip: |
| Home Phone: | Work Phone: | Cell Phone: |

**Primary Dental Insurance Information:**

| | | |
|---|---|---|
| Name of Insured (Policy Holder): | | Relationship to Insured: ○Self ○Spouse ○Child |
| Policy ID: | Insured Social Security #: | Insured Birth date: |
| Employer: | | Group #: |
| Address: | | Insurance Company: |
| Address 2: | | Address: |
| City, State, Zip: | | Address 2: |
| Medicaid ID: | | City, State, Zip: |

**Secondary Dental Insurance Information:**

| | | |
|---|---|---|
| Name of Insured (Policy Holder): | | Relationship to Insured: ○Self ○Spouse ○Child |
| Policy ID: | Insured Social Security #: | Insured Birth date: |
| Employer: | | Group #: |
| Address: | | Insurance Company |
| Address 2: | | Address: |
| City, State, Zip: | | Address 2: |
| Medicaid ID: | | City, State, Zip: |

# CHAMBERLAIN FAMILY DENTISTRY PATIENT POLICIES

*Our office policies statement is designed with you, the patient, in mind.*

**Financial Policy**

The fee for your treatment will be based on the extent of treatment and can vary greatly. Depending on the extent of your treatment, during your first visit we will discuss the probably number of visits, their length, and the fees involved. Fees vary based on the necessary procedure and it is our policy that your care is paid for at the time of treatment. Our office is committed to working with you and your insurance company to maximize your insurance benefits. We are preferred providers for Delta Dental, and we will file claims for all other major insurance companies on your behalf. In order for our office to file your insurance claims you must provide us with all the accurate information prior to your appointment. If we are unable to verify your insurance coverage you will be required to pay the entire balance at the time of your appointment. You are also responsible to make our office aware of any changes to your insurance. All deductibles and patient portions are due the day a service is provided. If your insurance company reimburses at a higher rate, we will provide you with a refund. Occasionally insurance companies will not cover the entire remaining balance. When this occurs, you will be responsible for the balance. Invoices over 30 days are subject to 1.5% monthly finance/late charge. If balance is not paid within 90 days, collections/legal action will be taken.

**Late Arrivals/Missed Appointment/Failure to Show/Cancellations**

We do not over-book our schedule. This means your appointment time is reserved especially for you. If you do not come, not only is your own care delayed, but no one else is able to be treated during that time. We expect our patients to arrive on time for their scheduled appointment. Please note that we will have to reschedule your appointment if you arrive more than 10 minutes late. All patients who fail to arrive for their reserved appointments or who cancel without 24 hours advance notice without contacting our office within the required time, will be considered a missed appointment. If you need to change your appointment, we ask for a minimum notice of 24 hours. According to our office policies, if a patient fails their initial first appointment, they will be dismissed and unable to reschedule any future appointments. Please be advised that you will be charged a fee for your missed appointments, amount to be determined at the discretion of Doctor McCready. This missed appointment fee is NOT covered by any insurance plans and is your responsibility to pay. If missed appointments become habitual, you will be required to make a nonrefundable deposit in advance and any missed future appointments will be charged an additional $100 missed appointment fee. After your third (3rd) missed appointment, you will be dismissed as a patient.

**Reminder Calls/Texts/Emails:**

Reminder calls/texts/emails are a courtesy to our patients. Please be sure to give us a current phone number/email where you can be reached for confirmation prior to your appointment. If this line is busy or otherwise unavailable, we regret that we do not have enough staff to repetitively attempt to contact you. For this reason, do not rely on a reminder call/text/email from our office staff.

**Guests in Treatment Areas**

Parents of patients are welcome to accompany their child during their visit to our office. However, we ask that parents allow their children to experience the office without parental support. This allows the child to establish an uninterrupted relationship with the doctor and dental assistant that enables them to gain confidence during dental treatment. Our staff is experienced and trained in early childhood behavior and will make a great effort to ensure that your child feels comfortable in these new surroundings. Since this first visit will establish their initial attitudes towards dentistry, it is very important to make this appointment a positive encounter. We also request that children under the age of 10, are accompanied by an adult in the waiting area while parent/s are with the Doctor or Hygienist.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read the policy above. I understand and agree to abide by the listed terms.

*Signature of Responsible Party:*_____ *Date:*_____

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information. 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. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patients Name [Printed]: _____

Patients Name [Signature]:_____

Date: _____

*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 treatment, and information about mental health services] to the following individuals:*

To whom may the information be released:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

*If this consent is signed by a personal representative on behalf of the patient, complete the following:*

Patients Name: _____

Parent/Legal Guardian Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____

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*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 ▫Other (please specify): _____