TIME 02:47 PM

**PATIENT REGISTRATION** 

DATE 6/17/2020

ID:	Chart ID:						
First Name:		Last Name:					Middle Initial:
Patient Is: Policy Holder	Responsible Party	Preferred Name:					
	e other than the patient ) –						
First Name:	- /	Last Name:					Middle Initial:
Address:		Addre	ess 2:				
City, State, Zip:							Pager:
Home Phone:	Work Phone:				Ext:	C	Cellular:
Birth Date:	Soc Sec:				Drivers	Lic:	
Responsible Party is also a Policy	Holder for Patient	Primary Insurance	e Policy Hold	er	Se	condary Insura	nce Policy Holder
——— Patient Information ———							
Address:		Addre	ess 2:				
City:		State / Zip:					Pager:
Home Phone:	Work Phone:				Ext:	C	ellular:
Sex: Male Fem	ale	Marital Status:	Married	Single	Divorced	Separated	Widowed
Birth Date:	Age:	So	c Sec:		Drivers	Lic:	
E-mail:			I would like t	o receive co	orrespondences via	e-mail.	
S	ection 2					- Section	3
Employment Full Time Status:	Part Time	Retired			Credit (	Cell Phone Card Number	
Student Status: Full Time	Part Time						
Medicaid ID:	Pref. Den	tist:					
Employer ID:	Pref. Pharma	acy:					
Carrier ID:	Pref. H	lyg:					
Primary Insurance Information	ı ———						
Name of Insured:			Relations	hip to Insur	ed: Self	Spouse	Child Other
Insured Soc. Sec:		Insured Birth I	Date:				
Employer:			Ins	. Company			
Address:				Address			
Address 2:				Address 2			
City, State, Zip:			City	, State, Zip			
Rem. Benefits:	Rem	. Deduct:	·				
Secondary Insurance Information	tion						
Name of Insured:			Relations	hip to Insur	ed: Self	Spouse	Child Other
Insured Soc. Sec:		Insured Birth I		r			
Employer:				. Company			
Address:				Address			
Address 2:				Address 2			
City, State, Zip:			City	, State, Zip:			
Rem. Benefits:	Rem	. Deduct:	City	, ~, Lip			

Patient Name:

## Landman Dental Care Eaglesoft Medical History(New)

Date Created:

Birth Date:

Date 6/17/2020

Are you under a physican's care non?  Yes No If yes Have you ever been hospitalized or had a major operation?  Yes No If yes Have you ever been hospitalized or had a major operation?  Yes No If yes Have you ever been hospitalized or had a major operation?  Yes No If yes  Are you along any medication, pile, or drug? Yes No If yes Do you take, or have you taken, Phen-Fen or Redu? Yes No If yes  Are you an special de? Yes No If yes  Are you an special de?  Yes No If yes  Are you are you bed, any of the following?  Are you are you bed, any of the following?  Are you are you bad, any of the following?  Are how backgroup Are you bed, any of the following?  Are you are you bed, any of the following?  Are how backgroup Are you bed, any of the following?  Are how backgroup Are you bed, any of the following?  Are how backgroup Are how ba												
Have you ever had a serious head or neds injury? Yes No If yes Are you taken, phen-Fen or Redux? Yes No If yes Do you take, or have you taken, phen-Fen or Redux? Yes No If yes Do you use tobacco? Yes No If yes Are you taken, phen-Fen or Redux? Yes No If yes Are you taken, phen-Fen or Redux? Yes No If yes Are you use tobacco? Yes No Do you use tobacco? Yes No Have you ever taken antibiotic premedication prior to dental Yes No Have you ever taken antibiotic premedication or not odental Yes No Have you ever taken antibiotic premedication prior to dental Yes No Have you ever taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication prior to dental Yes No Have you aver taken antibiotic premedication Premotily Apprin Apprin Apprin Coderne Yes No Do you have, or have you had, any of the following? Automity Souces Yes No Argina Yes No Do pay dadicton Yes No Hapatitis B or C Yes No Hapatitis B	Are you under a physician's	care now?	(	🔵 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 Do you use taken Rosanax, Boriva, Actorel or any other medications containing biphophonates? Are you on a special det? Yes No Have you ever taken antibiotic premedication prior to dental Yes No Have you oner taken antibiotic premedication prior to dental Yes No Have you oner taken antibiotic premedication prior to dental Yes No Have you oner taken antibiotic premedication prior to dental Yes No Have you oner taken antibiotic premedication prior to dental Yes No Have you oner taken antibiotic premedication prior to dental Yes No Have you alerçi to any of the following? Perginent/Trying to get pregnant? Nomen: Are you Perginent/Trying to get pregnant? Nomen: Ar	Have you ever been hospita	alized or had a majo	r operation?	) Yes	No	If yes	•					
Are you taking any medications, pills, or drugs? Viss No If yes Do you take, or have you taken, Phen-Fen or Redux? Viss No If yes Do you use tobacco? Viss No If yes Are you on a special diet? Viss No Have you ever taken Antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you aver taken antibiotic premedication prior to dental Viss No Have you ever taken antibiotic premedication prior to dental Viss No Have you aver taken antibiotic premedication prior to dental Viss No Have you aver taken antibiotic premedication prior to dental Viss No Have you aver taken antibiotic premedication prior to dental Viss No Have you have, or have you had, any of the following? ADS/HV Positive Aroy No Angrina Yes No Dirg Addicton Yes No Have Yes No Angrina Yes No Dirg Addicton Yes No Have Have Yes No Ha	Have you ever had a seriou	s head or neck inju	·v?	Nes (	No	If ves						
Do you take, or have you taken, hhen-fren or Redux? Yes No Have you are taken Fasanas, Boriva, Actorel or any other medications containing bisphosphonates? Are you an special det? Do you use taken ambiotic premedication prior to dental reatment? Vomen: Are you Pregnant/Trying to get pregnant? Pres No Have you are ver taken ambiotic premedication prior to dental reatment? Vomen: Are you Pregnant/Trying to get pregnant? Preside Asprin Asprin Metal Do you use controlled substances? Other? Taking oral contraceptives? Pregnant/Trying to get pregnant? Pregnant/Trying to get pregnant? Pregnant Pregnant/Trying to get pregnant? Pregnant Pregnant/Trying to get pregnant? Pregnant Pregnant Pregnant Pregnant Pregnant Pregna	Are you taking any medicati	ons, pills, or drugs										
Here you ever taken Fosamax, Boriva, Actonel or any other       Yes       No       If yes         Are you on a special det?       Yes       No       If yes         Do you use taken antbiotic premedication prior to dental treatment?       Yes       No         Image: A point in the point the point in the point in the point in the p												
Are you on a special det?       Yes       No         Do you use tobacco?       Yes       No         New you were take antibotic premedication prior to dental treatment?       Yes       No         Interve you:       Interve you:       Interve you:       Interve you:         Pregnant/Trying to get pregnant?       Nursing?       Interve you:         Interve you:       Pregnant/Trying to get pregnant?       Nursing?       Interve you:         Interve you were controlled substances?       Pres       No       If yes         Other?       If yes       Interve you had, any of the following?         Atbrains' Dicease       Yes       No       Hemophila       Yes       No         Alzheims' Dicease       Yes       No       Disbetes       Yes       No       Hepatitis & C       Yes       No         Anghri/Ausis       Yes       No       Easily Winded       Yes       No       Hepatitis & C       Yes       No       Recent Weight Loss       Yes         Anghri/Sout       Yes       No       Easily Winded       Yes       No       Hepatitis & C       Yes       No       Recent Weight Loss       Yes         Angina       Yes       No       Easily Winded       Yes       No       Hepatitis												
by you use taken antibiotic premedication prior to dental vession in the prevalue of the following?  Pregnant/Trying to get pregnant?  Pregnant/Trying to get pregnant?  Pregnant/Trying to get pregnant?  Prevalergic to any of the following?  Autrinit  Prevalue controlled substances?  Pres No  Prevalue controlled substances?  Prevalue controlled substances  Pres No  Prevalue controlled substances  Pres No			or any other	)Yes	) No	If yes						
here you ever taken antibiotic premedication prior to dental vess No  treatment?  ameri: Are you  Pregnant/Trying to get pregnant? Nursing?  Taking oral contraceptives?  re you alergic to any of the following?  Applin Penicilin Penicilin Cotaone Medicine Yes No If yes  to you use controlled substances? Yes No If yes  to you use, or have you had, any of the following?  ADS/htty Positive Yes No Drug Addiction Yes No Drug Addiction Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Angnina Yes No Endphysena Yes No Endphysena Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Artificial Heart Valve Yes No Endphysena Yes No Endphysena Yes No Heigh Blood Pressure Yes No Sorate Frever Yes No Stringed Yes No Stringe Yes No Stringed Yes No Stringe Yes No Stringed Y	Are you on a special diet?		0	🔵 Yes 🌘	No							
treatment?	Do you use tobacco?		(	🔵 Yes 🌘	No							
Pregnant/Trying to get pregnant?       Nursing?       Taking oral contraceptives?         re you allergic to any of the following?       Pencillin       Codeine       Acrylc         gaprin       Pencillin       Codeine       Acrylc         Metal       Latex       Sulfa Drugs       Local Anesthetics         Do you use controlled substances?       Yes       No       If yes         Other?       If yes		otic premedication p	rior to dental	🔵 Yes 🌘	) No							
re you allergic to any of the following?  Aprin  Pencialin  Pencialin  Pencialin  Pencialin  Pencialin  Pencialin  Catex  Sulfa Drugs  Acrylc  Local Anesthetics  Percent P	/omen: Are you											
Aspirin       Pericilin       Codeine       Acrylic         Metal       Latex       Sulfa Drugs       Local Anesthetics         Do you use controlled substances?       Yes       No       If yes         Other?       If yes	Pregnant/Trying to get	pregnant?		Nursing?				Tal	king oral	contraceptives?		
Metal       Latex       Sulfa Drugs       Local Anesthetics         Do you use controlled substances?       Yes       No       If yes         Other?       If yes       If yes         ADDs/HUP Positive       Yes       No       Contraction of the following?         ALDs/HUP Positive       Yes       No       Contraction of the following?         ALDs/HUP Positive       Yes       No       Contisone Medicine       Yes       No       Readiation Treatments       Yes         Alzheimer's Disease       Yes       No       Diabetes       Yes       No       Hemophilia       Yes       No       Readiation Treatments       Yes         Anaphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Rena Dialysis       Yes         Angina       Yes       No       Epolepsy or Seizures       Yes       No       High Blood Pressure       Yes       No       Rheumatism       Yes         Artthrids/Gout       Yes       No       Excessive Eleding       Yes       No       High Colosterol       Yes       No       Side Cell Disease       Yes         Attritic/Gout       Yes       No       Excessive Thirst       Yes	re you allergic to any of the	following?										
Do you use controlled substances?           Other?       If yes         Other?       If yes         ALDS/HU Positive       Yes       No         Alzheimer's Disease       Yes       No         Drug Addiction       Yes       No         Alzheimer's Disease       Yes       No         Drug Addiction       Yes       No         Anaphylaxis       Yes       No         Anaphylaxis       Yes       No         Angina       Yes       No         Emphysema       Yes       No         High Blood Pressure       Yes       No         Arthrits/Gout       Yes       No         Filespa or Secures       Yes       No         Arthrits/Jout       Yes       No         Frequent Cough       Yes       No         Frequent Cough       Yes       No         Blood Disease       Yes       No         Blood Tosease       Yes       No         Frequent Headaches       Yes       No         Hurge Silve Easily       Yes       No         Frequent Headaches       Yes       No         Brood Transfusion       Yes       No         Frequent Headaches       Y	Aspirin		Penicillin				Codeine			Acrylic		
Dther?       If yes         Oppoundate, or have you had, any of the following?         AIDS/HIV Positive       Yes       No         Alzheimer's Disease       Yes       No         Orgonization       Yes       No         Anaphylaxis       Yes       No         Diabetes       Yes       No         Anaphylaxis       Yes       No         Anemia       Yes       No         Angina       Yes       No         Arthritis/Gout       Yes       No         Arthritis/Gout       Yes       No         Arthritis/Idial Heart Valve       Yes       No         Faiting Spells/Dizziness       Yes       No         High Blood Pressure       Yes       No         Recessive Thirst       Yes       No         High Cholesterol       Yes       No         Silood Transfusion       Yes       No         Frequent Cough       Yes       No         Blood Transfusion       Yes       No         Frequent Headaches       Yes       No         Blood Disease       Yes       No         Broathise Theres       No       Frequent Headaches       Yes       No <t< td=""><td>Metal</td><td></td><td>Latex</td><td></td><td></td><td></td><td>Sulfa Drugs</td><td></td><td></td><td>Local Anesthetics</td><td></td><td></td></t<>	Metal		Latex				Sulfa Drugs			Local Anesthetics		
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         Alzheimer's Disease       Yes       No       Diabetes       Yes       No       Hepatitis A       Yes       No       Recent Weight Loss       Yes         Anaphylaxis       Yes       No       Drug Addiction       Yes       No       Hepatitis B or C       Yes       No       Renal Dialysis       Yes         Anemia       Yes       No       Easily Winded       Yes       No       Heipatitis B or C       Yes       No       Renumatic Fever       Yes         Angina       Yes       No       Easily Winded       Yes       No       High Blood Pressure       Yes       No       Recart Weight Loss       Yes         Artificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       High Cholesterol       Yes       No       Sindle Cell Disease       Yes         Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Irregular Heartbeat       Yes       No       Sindle Cell Disease       Yes         Blood Disease	Do you use controlled subst	ances?	(	)Yes	) No	If yes						
AIDS/HIV PositiveYesNoCortisone MedicineYesNoHemophiliaYesNoRadiation TreatmentsYesAlzheimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRecent Weight LossYesAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRenal DialysisYesAnemiaYesNoEasily WindedYesNoHerpesYesNoRheumatic FeverYesAnginaYesNoEpilepsy or SeizuresYesNoHigh Blood PressureYesNoScarlet FeverYesArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoSinglesYesArtificial JointYesNoFainting Spells/DizzinessYesNoHives or RashYesNoSinus TroubleYesBlood DiseaseYesNoFrequent ClughtYesNoKidney ProblemsYesNoSinus TroubleYesBlood TransfusionYesNoGenital HerpesYesNoLuver DiseaseYesNoStomach/Intestinal DiseaseYesBruise EasilyYesNoGenital HerpesYesNoLuver DiseaseYesNoStomach/Intestinal DiseaseYesBruise EasilyYesNoGenital HerpesYesNoLuver DiseaseYesNoStomach/Intestinal DiseaseYes<	Other?					If yes						
AIDS/HIV PositiveYesNoCortisone MedicineYesNoHemophiliaYesNoRadiation TreatmentsYesAlzheimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRecent Weight LossYesAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRecent Weight LossYesAnemiaYesNoEasily WindedYesNoHerpesYesNoRheumatic FeverYesAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumatismYesArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoScarlet FeverYesArtificial JointYesNoFainting Spells/DizzinessYesNoHives or RashYesNoSindle Cell DiseaseYesBlood DiseaseYesNoFrequent CoughYesNoKidney ProblemsYesNoSinus TroubleYesBlood TransfusionYesNoGenital HerpesYesNoLuver DiseaseYesNoStomach/Intestinal DiseaseYesBruise EasilyYesNoGenital HerpesYesNoLuver DiseaseYesNoStomach/Intestinal DiseaseYesCancerYesNoGenital HerpesYesNoLurg DiseaseYesNoStomach/Intestinal DiseaseYes		1 6 ik - 6 ik										
Alzheimer's Disease       Yes       No       Diabetes       Yes       No       Hepatitis A       Yes       No       Recent Weight Loss       Yes         Anaphylaxis       Yes       No       Drug Addiction       Yes       No       Hepatitis B or C       Yes       No       Recant Weight Loss       Yes         Anemia       Yes       No       Easily Winded       Yes       No       Herpes       Yes       No       Rheumatic Fever       Yes         Angina       Yes       No       Epilepsy or Seizures       Yes       No       High Blood Pressure       Yes       No       Rheumatism       Yes         Arthritis/Gout       Yes       No       Excessive Bleeding       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes         Arthficial Joint       Yes       No       Excessive Thirst       Yes       No       Hypoglycemia       Yes       No       Sinde Cell Disease       Yes         Blood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Stonach/Intestinal Disease       Yes         Blood Transfusion       Yes       No       Frequent Headaches       Yes			1		O Ves	No	Hemophilia	M Yes	No	Radiation Treatments	O Ves	No
AnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRenal DialysisYesAnemiaYesNoEasily WindedYesNoHerpesYesNoRheumatic FeverYesAnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumatismYesArthritis/GoutYesNoEplepsy or SeizuresYesNoHigh Blood PressureYesNoScarlet FeverYesArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoSidde Cell DiseaseYesArtificial JointYesNoFainting Spells/DizzinessYesNoHrypoglycemiaYesNoSinus TroubleYesBlood DiseaseYesNoFrequent CoughYesNoKidney ProblemsYesNoStomach/Intestinal DiseaseYesBlood TransfusionYesNoFrequent DiarrheaYesNoLeukemiaYesNoStomach/Intestinal DiseaseYesBruise EasilyYesNoGenital HerpesYesNoLiver DiseaseYesNoStomach/Intestinal DiseaseYesCherotherapyYesNoGaucomaYesNoLug DiseaseYesNoStowach/Intestinal DiseaseYesCherotherapyYesNoGaucomaYesNoLug DiseaseYesNoThryoid DiseaseYesCheroth					_	_						
Anemia       Yes       No       Easily Winded       Yes       No       Herpes       Yes       No       Rheumatic Fever       Yes         Angina       Yes       No       Emphysema       Yes       No       High Blood Pressure       Yes       No       Rheumatism       Yes         Arthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes         Artfridial Joint       Yes       No       Excessive Bleeding       Yes       No       High Cholesterol       Yes       No       Sindle Cell Disease       Yes         Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Irregular Heartbeat       Yes       No       Sinus Trouble       Yes         Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Blood Transfusion       Yes       No       Frequent Headaches       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes					-	_		-	_		_	_
AnginaYesNoEmphysemaYesNoHigh Blood PressureYesNoRheumatismYesArthritis/GoutYesNoEpilepsy or SeizuresYesNoHigh CholesterolYesNoScarlet FeverYesArthritis/GoutYesNoExcessive BleedingYesNoHives or RashYesNoShinglesYesArtificial JointYesNoExcessive ThirstYesNoHypoglycemiaYesNoSickle Cell DiseaseYesAsthmaYesNoFainting Spells/DizzinessYesNoIrregular HeartbeatYesNoSinus TroubleYesBlood DiseaseYesNoFrequent CoughYesNoLeukemiaYesNoStomach/Intestinal DiseaseYesBlood TransfusionYesNoFrequent HeadachesYesNoLiver DiseaseYesNoStomach/Intestinal DiseaseYesBreathing ProblemsYesNoGenital HerpesYesNoLiver DiseaseYesNoStokeYesCharcerYesNoGlaucomaYesNoLung DiseaseYesNoTomslitisYesYesChertherapyYesNoHay FeverYesNoOsteoporosisYesNoTuberculosisYesChertherapyYesNoHeart Attack/FailureYesNoOsteoporosisYesNoTuberculosisYesChertherapyYes <td></td> <td></td> <td>-</td> <td></td> <td>_</td> <td>_</td> <td></td> <td>_</td> <td>_</td> <td></td> <td>_</td> <td>_</td>			-		_	_		_	_		_	_
Arthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes         Artificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       Hives or Rash       Yes       No       Scarlet Fever       Yes         Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Hypoglycemia       Yes       No       Singles       Yes         Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Kidney Problems       Yes       No       Sinus Trouble       Yes         Blood Disease       Yes       No       Frequent Cough       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Blood Transfusion       Yes       No       Frequent Headaches       Yes       No       Liver Disease       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Gaucoma       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Chemotherapy       Yes       No       Hay Fever       Yes </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td>-</td> <td>-</td> <td></td> <td>-</td> <td>-</td>					-	-		-	-		-	-
Artificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       Hives or Rash       Yes       No       Shingles       Yes         Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Hives or Rash       Yes       No       Sickle Cell Disease       Yes         Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Irregular Heartbeat       Yes       No       Sinus Trouble       Yes         Blood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Stomach/Intestinal Disease       Yes         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Chemotherapy       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Tossillitis       Yes         Chest Pains       Yes       No       Heart Attack/Failure					_	_	-					
Artificial Joint       Yes       No       Excessive Thirst       Yes       No       Hypoglycemia       Yes       No       Sidkle Cell Disease       Yes         Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Irregular Heartbeat       Yes       No       Sinus Trouble       Yes         Blood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Stomach/Intestinal Disease       Yes         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Breathing Problems       Yes       No       Frequent Headaches       Yes       No       Low Blood Pressure       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Topsilitis       Yes         Chest Pains       Yes       No       Heart Attack/Failure						_	2	_	_		-	_
Asthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Irregular Heartbeat       Yes       No       Sinus Trouble       Yes         Blood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Spina Bifda       Yes         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Breathing Problems       Yes       No       Frequent Headaches       Yes       No       Liver Disease       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Trovid Disease       Yes         Chemotherapy       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Y			-	,							_	_
Blood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Spina Bifida       Yes         Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Breathing Problems       Yes       No       Frequent Headaches       Yes       No       Liver Disease       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         Chemotherapy       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker <td></td>												
Blood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Breathing Problems       Yes       No       Frequent Headaches       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         Chemotherapy       Yes       No       Haart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tumors or Growths       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes				ziness	_	-	-	-	_			_
Breathing Problems       Yes       No       Frequent Headaches       Yes       No       Liver Disease       Yes       No       Stroke       Yes         Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         Chemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsilitis       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Attack/Failure       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes						_		-	-		_	
Bruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         Chemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsilitis       Yes         Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Parathyroid Disease       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes					_	_		-	_		-	_
Cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes       Yes         Chemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsillitis       Yes       Yes         Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes				es								
Chemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsillitis       Yes       Yes         Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Attack/Failure       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes												
Chest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes       Yes         Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes		🔘 Yes 🔘 No			Yes	No		Yes	No		Yes	No
Cold Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         Congenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes		🔘 Yes 🔘 No			Yes	No		Yes	No		Yes	No
Congenital Heart Disorder O Yes O No Heart Pacemaker O Yes O No Parathyroid Disease O Yes O No Ulcers O Yes	Chest Pains	🔘 Yes 🔘 No	Heart Attack/Failur	re	Yes	No	Osteoporosis	Yes	No		Yes	No
	Cold Sores/Fever Blisters	🔘 Yes 🔘 No	Heart Murmur		Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Convulsions 💿 Yes 💿 No Heart Trouble/Disease 💿 Yes 💿 No Psychiatric Care 💿 Yes 💿 No Venereal Disease 💿 Yes	Congenital Heart Disorder	🔘 Yes 🔘 No	Heart Pacemaker		Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
	Convulsions	🔘 Yes 🔘 No	Heart Trouble/Dise	ase	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice 🖉 Yes 🖉 No Neurologic Disorders 🖉 Yes 🖉 No	Yellow Jaundice	🔘 Yes 🔘 No	Neurologic Disorde	rs	Yes	No						
Have you ever had any serious illness not listed above? Orego No If yes	Have you ever had any seri	ous illness not liste	above?	)Yes	No	If yes	÷			·		

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:

Date:\_\_\_\_\_

## Dental History

# Welcome! So that we may provide you with the best possible care please complete both sides of this dental history form. All information is completely confidential.

What is the reason for your visit too	lay?				
Date of Last Dental Visit		Last	Dental Cleaning		
Last Full Mouth X-Rays			J		
Previous Dentist Name					
			State	Zip	
How often do you have dental exan	nination	ıs?			
How often do you brush your teeth?	?		How often do you floss?		
			thpick, etc.)		
Do you have any dental problems	now?	Yes	No		
If yes, please describe:					
Are any of your teeth sensitive to:	:		Does food tend to become caught		
Hot or Cold?	Yes	No	in between your teeth?	Yes	No
Sweets?	Yes	No	If yes, where?		
Biting or Chewing?	Yes	No			
Have you noticed any mouth			Do you:		
odors or bad tastes?	Yes	No	Clench or grind your teeth while		
Do you frequently get cold sores			awake or asleep?	Yes	No
blisters, or any other oral lesions?	Yes	No	Bite your lips or cheeks regularly?	Yes	No
			Hold foreign objects with your		
Do your gums bleed or hurt?	Yes	No	teeth? (pencils, pipe, pins, nails,		
Have your parents experience			fingernails, etc.)	Yes	No
gum disease or tooth loss?	Yes	No	Mouth breathe while awake or		
Have you noticed any loose teeth			asleep?	Yes	No
or change in your bite?	Yes	No			

Have tired jaws, especially in the			Pain? (joint, ear, side of face)	Yes	No
morning?	Yes	No	Difficulty in opening or closing		
Smoke/chew tobacco?	Yes	No	the mouth?	Yes	No
			Headaches, neck aches, or shoulder		
Have you ever had:			aches?	Yes	No
Orthodontic treatment?	Yes	No	Sore muscles (neck, shoulders)?	Yes	No
Oral surgery?	Yes	No			
Periodontal treatment?	Yes	No	Are you satisfied with your teeth's	5	
Your teeth ground or the bite			appearance?	Yes	No
adjusted?	Yes	No	Would you like to keep all of your		
A bite plate or mouth guard?	Yes	No	teeth all of your life?	Yes	No
A serious injury to the mouth or			Do you feel nervous about having		
head?	Yes	No	dental treatment?	Yes	No
If so, please describe, including cau	ise:		If so, what's your biggest concern?		
			Have you ever had an upsett	ing den	tal
			experience?	Yes	No
Have you experienced:			If yes, please describe:		
Clicking or popping of the jaw?	Yes	No			

### Is there anything else about having dental treatment that you would like us to know?

If yes, please describe:

\_\_\_\_\_

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_\_\_''s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature	Date	

Witness

Parent/Responsible Party's Signature \_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_

Landman Dental Associates 737 N Michigan Ave. Suite 610 Chicago IL, 60611 Phone 312-266-6480 Fax 773-897-5853 office@landmandental.com

#### LANDMAN DENTAL ASSOCIATES

Patient

Date

Welcome to the Practice. Thank you for choosing LANDMAN DENTAL for your dental needs. We are so happy you are here. We are here to make your visit with us a very pleasant experience. Let us know how we may assist you.

#### CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above-named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

#### **TERMS AND CONDITIONS**

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment at the time of service, unless other payment arrangements have been approved in advanced by our team. We accept payment for services in cash, check, Mastercard, Visa, Discover, and American Express. We will explain your dental treatment costs to you.

#### **INSURANCE**

If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies. **Your insurance company will directly reimburse you**. This dental office cannot render services on the assumption that charges will be paid by an insurance company. Treatment diagnosed is not based on insurance but on dental needs. We take pride in the quality of care we offer our patients and make every effort to have your visits with us be as easy as possible.

#### **COLLECTION AUTHORIZATIONS**

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand upon non-payment for service and in the event of multiple billing, I will be assessed a rebilling fee of \$35.00. I, the undersigned here by agree that in the event of default in the payment of any amount due, and if this account is placed with a collection agency, for collection or any subsequent legal action, to pay an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions. THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED 48 HOURS BEFORE THE APPOINTMENT TIME

By signing below, I certify that I have read, understand and agree to all of the guidelines and authorizations mentioned above.

Signature of Responsible Party	Date
Signature of Patient	Date

LANDMAN DENTAL ASSOCIATES 737 N. Michigan Avenue Chicago II

## LANDMAN DENTAL ASSOCIATES

737 N Michigan Ave, Suite 610, Chicago, IL 60611

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- 1. Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment direct and indirectly.
- 2. Obtain payment from third-party payers.
- 3. Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carryout treatment, payment or health care operation. I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

### **REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

Patient Name (Print)	Date of Birth	
Relationship to patient		
Signature	Date	
Written Communications:		
Address to:		

If the address provided above is not your home address or is not a street address, please provide us with a current street address for purposes of ensuring payment.