Please take your time to fill out these forms completely. The more we learn about you the better care we can provide.

Patient Information

Today's Date: ________________________

Legal First Name: _________________________________Middle Initial: _____ Last Name: _________________________________

I prefer to be called (Nickname, etc.): ______________________________ □ Male □ Female □ Other: ________________________

Date of Birth: ____________________________________ Social Security Number: ____

Mailing Address: ____

City: ____ State: ____________ Zip Code: ____________________________

Contact Number: (_________)__________-_____________________ □ Home □ Cell □ Work □ Other: _______________________

Alternate contact number: (_________)_________-___________________ □ Home □ Cell □ Work □ Other: __________________

Email: ____

Employer: ____ Occupation: ____

Spouse's Name: ____ Employer: ____

Emergency contact name: ____

Relationship: ____ Phone Number: (_________)__________-_____________________

Any Changes to your insurance? □ Yes □ No

If yes, please provide the staff with an updated card:

Subscriber's Name: ____ Subscriber DOB: _________________________

Relationship to patient: ____

Subscriber Social security number and/or Insurance ID number: ____

Insurance Company & Mailing address: ____

Insurance Phone number: (________)_______________________________ Electronic payer number: _________________________

Fees and Past Due Accounts:

A late fee of ten dollars ($10) per month may be applied to accounts that are not paid within twenty-five (25) days of the statement.

A finance charge will be imposed on each item of your account that has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at a monthly percentage rate of one percent (1%) per month, or at an annual percentage rate of twelve percent (12%) per year. You also agree to pay all attorney fees and cost of collection incurred if your account is not paid as agreed.

A missed appointment fee of fifty ($50) for any appointment when an appointment is either abandoned (no-call, no-show) or canceled within 24 hours of the appointment date without a valid reason. This fee is not covered by any insurance. Any appointments scheduled after the fee is applied to your account will be canceled until paid in full.

Patients missing an excessive number of appointments will be dismissed from our practice

Patient name: ____ Legal Guardian: ____________________________________

Patient or legal guardian signature: ____ Date: ___________________________

Last updated: 19 March 2025

Medical History

Within the last 2 years have you had any hospitalizations, illnesses, or operations? □ Yes □ No

If yes, please describe: ____

Hospital or Physician: ______________________________ Phone: (________)______________________

Are you currently taking any medications? (Include regular doses of aspirin or over-the-counter medications): □ Yes □ No

If yes, please List: ____

(Use the back of this page if you need more room, or if you have a current list ask the front desk to take a copy)

WOMEN: Are you currently taking birth control: □ Yes □ No

Are you pregnant? □ Yes □ No □ Maybe Due Date: ______________________ Are you nursing? □ Yes □ No

MEN/WOMEN: Please check any of the following issues:

□ Acid Reflux/GERD
□ AIDS/HIV
□ Alcohol/Drug Abuse
□ Allergies or Hives
□ Anemia
□ Arthritis/Rheumatism
□ Artificial Heart Valve
□ Artificial Bones/Joints
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Bruise Easily
□ Cancer/Chemotherapy
□ Chest Pain
□ Circulatory Problems
□ Cold Sores/Herpes
□ Colitis
□ Contact Lenses
□ Cortisone Medicine
□ Cough, persistent
□ Diabetes
□ Diet (Special/Restricted)
□ Difficulty Breathing
□ Emphysema
□ Epilepsy or Seizures
□ Fainting or Dizzy Spells
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Heart Attack, year: _________
□ Heart Disease
□ Heart Surgery, year: ________
□ Heart Pacemaker
□ Heart Murmur
□ Hemophilia/Abnormal Bleeding
□ Hepatitis A B C (circle)
□ High Blood Pressure
□ High Cholesterol
□ Hospitalized for Any Reason
□ Jaundice
□ Kidney Disease/Trouble
□ Liver Disease/Trouble
□ Low Blood Pressure
□ Lupus
□ Malignant Hyperthermia
□ Mitral Valve Prolapse
□ Nervousness/Anxiety
□ Neurological Disorders
□ Psychiatric/Psychological Care
□ Radiation Therapy
□ Respiratory Disease/Trouble
□ Rheumatic/Scarlet Fever
□ Shingles/Chicken Pox
□ Sickle Cell Disease/Traits
□ Sinus Trouble
□ Smoking Habit (Tobacco, marijuana, etc.)
□ Snoring/Sleep Apnea
□ Stomach Problems/ Ulcers
□ Stroke
□ Swollen Ankles
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis (TB)
□ Tumors
□ Other: ________________

Are you aware of having any allergic or adverse reactions to any of the following medications:

Aspirin	□ Yes	□ No	Iodine	□ Yes	□ No	Sedatives	□ Yes	□ No
Codeine	□ Yes	□ No	Jewelry/Metals	□ Yes	□ No	Sulfa Drugs	□ Yes	□ No
Anesthetics (i.e. Novocain)	□ Yes	□ No	Latex	□ Yes	□ No	Tetracycline	□ Yes	□ No
Erythromycin	□ Yes	□ No	Penicillin or other antibiotics	□ Yes	□ No	□ other: __________________		

If yes, please describe: ____

Please list any medical conditions that you have had that are not listed above: ______________________________

____

Patient name: ______________________________ Legal Guardian: ______________________________

Patient or legal guardian signature: ______________________________ Date: ______________________

Last updated: 19 March 2025

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(P) 907-562-6648

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Eagle River
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Midnight Sun Dental
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