Patient Information

Full name:_____

Street Address:_____

City_____State_____ZipCode:_____

Home Phone:_____Work_____Cell:_____

D.O.B._____SocialSecurity#_____Sex:Male/Female

E-Mail: _____Preferred Method of Contact:_____

Responsible Party: Fill out if the responsible party is someone other than the patient

Full Name:_____

Relationship to patient :_____

Address:_____

Home Phone:_____work:_____Cell:_____D.O.B _____

Insurance Information

Name of Insured:_____

Patient's relationship to insured: (circle): Self Spouse Dependent Other:_____

Insured's address :_____

City_____State_____Zip Code:_____

Insured S.S.#_____ ID#_____ Group #_____

Insured D.O.B. _____Insured Phone _____

Employer:_____City/State_____

Insurance Company:_____

Emergency Contact:_____Phone:_____

Who should we thank for referring you, or how did you hear about us? Please circle one:

My Insurance Company Friend/Current Patient_____

Newspaper Flyer Phonebook Walk-In Drove-by Website

Gena Milligan, DDS

Eaglesoft Medical History

Date 4/20/2017

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	Tonsilitis	○ 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:_____

Acknowledgement of Receipt
Of
Notice of Privacy Practices

Date:_____

I,_____ have been offered a copy or read **Gene Milligan, D.D.S.** Notice of Private Practices.

Signature of Patient_____

Staff will Fill out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice Of Privacy Practices, but it could not be obtained for the following reasons:

_____Patient refused to sign.

_____Emergency situation kept us from obtaining for the patient's signature.

_____Language barriers kept us from obtaining the patient's signature

_____Other_____

Dr.Gene Milligan D.D.S
1430 Old Ranch Rd 12
San Marcos, Texas 78666
512-392-6739

HIPPA Consent to Leave Message

Patient Name:_____

Date:_____

I wish to be called at home◯; other (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

_____Home_____Other

I Do◯, I do not ◯ give permission to leave relevant medical/dental information on my answering machine or voicemail.

I do ◯, I do not ◯ want relevant medical/dental information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

_____

_____

Patient Signature_____

Date_____

Gene Milligan, D.D.S.
1430 Old Ranch Road 12
San Marcos, Texas 78666
Phone- 512-392-6739
Fax- 512396-0394

MISSED APPOINTMENT FEE NOTICE

In order to provide quality dental care, it is important that we hear from you prior to your appointment if you are unable to come in. Continued missed appointments may result in dismissal from our practice. In order to prevent paying a $45.00 missed appointment fee, appointments must be canceled at least 4 hours in advance. We would appreciate if you could give us a call 24 hours in advance if you need to reschedule your appointment.

Thank You
Gene Milligan, D.D.S.

Patient Signature_____

Date_____