

# Stonebridge Dental

6633 W. Eldorado Pkwy, Ste. 100 | McKinney, TX 75070

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First M  Married  Single  Minor  Male  Female  
Address \_\_\_\_\_  
Street Apt # City State Zip  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
If Full-time Student, School Name \_\_\_\_\_

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
Name of person or office referring you to our practice \_\_\_\_\_

## INSURANCE INFORMATION

Primary  
Name of Insured \_\_\_\_\_ Is insured a patient?  Yes  No  
Insured's Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Address \_\_\_\_\_  
Street Apt # City State Zip  
Insured's Employer's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip  
Patient's relationship to insured:  Self  Spouse  Child  Other  
Insurance Plan Name and Address \_\_\_\_\_

## AUTHORIZATION (All Patients or Guardians must sign)

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

\_\_\_\_\_  
Patient's or Guardian's Signature Date \_\_\_\_\_

## New Eaglesoft Medical History

Patient First Name

Patient Last Name

Do you have, or have you had, any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADHD                       | <input type="checkbox"/> AIDS/HIV Positive        | <input type="checkbox"/> Alzheimer's Disease       |
| <input type="checkbox"/> Anaphylaxis                | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Angina                    |
| <input type="checkbox"/> Arthritis/Gout             | <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Artificial Joint          |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Blood Disease             |
|   |   | <input type="checkbox"/> Blood Transfusion         |
| <input type="checkbox"/> Breathing Problems         | <input type="checkbox"/> Bruise Easily            | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Chest Pains              | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Congenital Heart Disorder  | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Cortisone Medicine        |
|   | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Drug Addiction            |
| <input type="checkbox"/> Easily Winded              | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Epilepsy or Seizures      |
| <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Excessive Thirst         | <input type="checkbox"/> Fainting Spells/Dizziness |
| <input type="checkbox"/> Frequent Cough             | <input type="checkbox"/> Frequent Diarrhea        | <input type="checkbox"/> Frequent Headaches        |
| <input type="checkbox"/> Genital Herpes             | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Hay Fever                 |
| <input type="checkbox"/> Heart Attack/Failure       | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Heart Pacemaker           |
| <input type="checkbox"/> Heart Trouble/Disease      | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Hepatitis A               |
| <input type="checkbox"/> Hepatitis B or C           | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Hives or Rash            | <input type="checkbox"/> Hypoglycemia              |
| <input type="checkbox"/> Irregular Heartbeat        | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Leukemia                  |
| <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Lung Disease              |
| <input type="checkbox"/> Mitral Valve Prolapse      | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Pain in Jaw Joints        |
| <input type="checkbox"/> Parathyroid Disease        | <input type="checkbox"/> Psychiatric Care         | <input type="checkbox"/> Radiation Treatments      |
| <input type="checkbox"/> Recent Weight Loss         | <input type="checkbox"/> Renal Dialysis           | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Rheumatism                 | <input type="checkbox"/> Scarlet Fever            | <input type="checkbox"/> Shingles                  |
| <input type="checkbox"/> Sickle Cell Disease        | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Spina Bifida              |
| <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Swelling of Limbs         |
|   | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Tumors or Growths        | <input type="checkbox"/> Ulcers                    |
| <input type="checkbox"/> Venereal Disease           | <input type="checkbox"/> Yellow Jaundice          |  |

Have you ever had any serious illness not listed above? \*

- No  Yes

Are you under a physician's care now? \*

- No  Yes

Have you ever been hospitalized or had a major operation? \*

- No  Yes

Have you ever had a serious head or neck injury? \*

- No  Yes

Are you taking any medications, pills, or drugs? \*

- No  Yes

Do you take, or have you taken, Phen-Fen or Redux? \*

- No  Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? \*

- No  Yes

Are you on a special diet? \*

- No  Yes

Do you use tobacco? \*

- No  Yes

Do you use controlled substances? \*

- No  Yes

Women: Are you...

- Pregnant/Trying to get pregnant?  Nursing?  
 Taking oral contraceptives?

Are you allergic to any of the following?

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Codeine     | <input type="checkbox"/> Acrylic           |
| <input type="checkbox"/> Metal       | <input type="checkbox"/> Latex             |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics |

Other? \*

- No  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.

Draw your signature into the box below. \*

[Clear](#)

Relationship to the patient \*

Name if not the patient \*

[Continue](#)