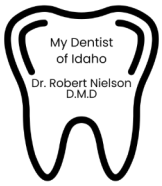


How did you hear about our office? _____

Personal Information

Name _____ Nickname _____ Birth Date _____

Spouse's Name _____ If patient is a minor, Parent or Guardian's name _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email Address _____

Home Address _____ City _____ Zip _____

Driver's License # _____ State _____ Social Security # _____

Employer _____ Occupation _____

Emergency Contact _____ Phone # _____

Relationship _____

Insurance Information

☐ No Dental Insurance

PRIMARY Insurance Company _____ Group # _____

Name of Insured _____ SSN _____ Insured Birth Date _____

Employer _____ ID Number _____

Relationship to Insured _____

SECONDARY Insurance Company _____ Group # _____

Name of Insured _____ SSN _____ Insured DOB _____

Employer _____ ID Number _____

Relationship to Insured _____

Patient Signature _____

Print Name _____ Date _____

Time 11:43 AM | Robert D. Nielson, D.M.D., PA | Date 10/6/2023

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

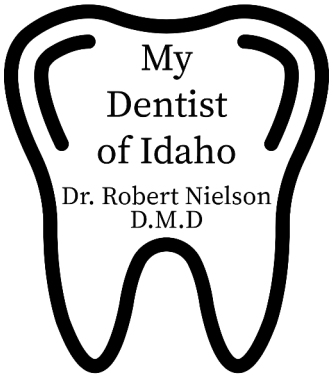
Have you ever had any serious illness not listed above? Yes No If yes

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:_____



Authorization to Release Information

Dr. Robert Nielson is hereby authorized to release and/or request any medical/dental or incidental information that may be necessary for either dental care or in the process of an application for financial benefit.

The following family members or close persons are authorized to receive my medical/dental information:

_____

_____

_____

_____

Patient or Responsible Party's Signature: Date:

_____ _____

My Dentist of Idaho
Dr. Robert Nielson D.M.D

Financial Policy Form

Thank you for choosing My Dentist as your personal dental team. To encourage a long-term mutually satisfying relationship, we have listed our office policies regarding treatment, insurance, appointments and fees. PLEASE read this carefully, and ask any questions or concerns you may have BEFORE treatment is rendered.

Treatment: Our entire staff is dedicated to helping you improve your dental health as professionally and quickly as possible. Our goal is to make sure your appointment is as comfortable and pleasant as possible. Please feel free to discuss your treatment with the Doctor at anytime.

Insurance: As a courtesy to you, our office files a claim with your insurance. If our office is able to accept your insurance company's assignment, the patient is still FULLY RESPONSIBLE for the charges of treatment rendered. Your insurance may not cover the services or may only partially cover them and any estimate given by this office is considered a guideline until the final insurance payment is received and the patient's account is reconciled. Our office can make NO GUARANTEE of the actual payment by your insurance company. For services that have been predetermined, the amount the insurance company may pay may be subject to maximums, deductibles, limitations, and non-payment due to employment status.

Missed Appointments: When we schedule your appointment, the time is reserved exclusively for you and the Doctor. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you kindly give our office at least 24 hours notice when you cannot keep your appointment. When the requested notice is not given, a fee may be charged.

PAYMENT IS DUE AT THE TIME OF SERVICES: We accept cash, personal checks, Master Card, Discover, American Express, and Visa. When insurance applies we may collect any deductible and estimated co-payment at time of service rendered. There is also a $25 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.

Prosthetics: Crowns, Dentures, Bridges etc. Failure by patient to return for the delivery of these items is subject to Doctor's time and lab fee charges.

Monthly Billing: Even though an insurance claim has been filed, you may receive a statement each month. If there is a balance due on your account you, not the insurance company, are responsible for the payment on your account.

Collection Fees: Fees incurred to enforce payment required by this agreement will be charged to the patient.

Signature: _____ Date: _____

Patient/Parent or Legal Guardian if patient is a minor