John C Woodall, DDS PA

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

	, acknowledge that I have
(Please Print Name)	•
received a copy of the Notice of Privacy F	Practices from John C Woodall, DDS PA
on this the day of	20
Patient Signature	
Date	
*You may refuse to sign this acknowledg	ement
For Office	Use Only
refuse	ed to sign the NPP on
Name of Patient	
Remarks:	

Patient Name:

Date 10/20/2020

Eaglesoft Medical History

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? OYes ONo If yes Have you ever been hospitalized or had a major operation? If yes ○Yes ○No Have you ever had a serious head or neck injury? ○Yes ○No If yes Are you taking any medications, pills, or drugs? O Yes O No If yes Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If yes Have you ever taken Fosamax, Boniva, Actonel or any other ○Yes ○No If ves medications containing bisphosphonates? O Yes O No Are you on a special diet? Do you use tobacco? ○ Yes ○ No If yes Do you use controlled substances? OYes ONo Women: Are you... Taking oral contraceptives? Pregnant/Trying to get pregnant? Nursing? Are you allergic to any of the following? Acrylic Codeine Penicillin Aspirin Sulfa Drugs Local Anesthetics Latex Metal Other? Do you have, or have you had, any of the following? ○Yes ○No OYes ONo Radiation Treatments ○Yes ○No Hemophilia OYes ONo Cortisone Mediane AIDS/HIV Positive Recent Weight Loss O Yes O No OYes ONo OYes ONo Hepatitis A ○Yes ○No Diabetes Alzheimer's Disease OYes ONo ○Yes ○No ○Yes ○No Hepatitis B or C Renal Dialysis OYes ONo Drug Addiction Anaphylaxs OYes ONo Rheumatic Fever ○Yes ○No ○Yes ○No OYes ONo Herpes Easily Winded Anemia ○Yes ○No Rheumatism ○Yes ○No High Blood Pressure ○Yes ○No OYes ONo Emphysema Angina ○Yes ○No Scarlet Fever OYes ONo ○Yes ○No High Cholesterol OYes ONo Epilepsy or Seizures Arthritis/Gout Shingles ○Yes ○No ○Yes ○No Hives or Rash OYes ONo Artificial Heart Valve OYes ONo Excessive Bleeding OYes ONo Sickle Cell Disease Hypoglycemia ○Yes ○No OYes ONo Excessive Thirst OYes ONo Artificial Joint ○Yes ○No Sinus Trouble OYes ONo Fainting Spells/Dizziness ○Yes ○No Irregular Heartbeat ○Yes ○No Asthma OYes ONo ○Yes ○No Spina Bifida OYes ONo Kidney Problems Frequent Cough ○Yes ○No Blood Disease Stomach/Intestinal Disease ○Yes ○No ○Yes ○No Leukemia OYes ONo Frequent Diarrhea OYes ONo Blood Transfusion OYes ONo ○Yes ○No Stroke OYes ONo Liver Disease Breathing Problems Frequent Headaches OYes ONo OYes ONo Swelling of Limbs ○Yes ○No OYes ONo Low Blood Pressure ○Yes ○No Genital Herpes Bruise Easily Thyroid Disease ○Yes ○No OYes ONo ○Yes ○No Lung Disease Glaucoma OYes ONo Cancer ○Yes ○No OYes ONo Tonsillitis Mitral Valve Prolapse ○Yes ○No Hay Fever OYes ONo Chemotherapy ○Yes ○No OYes ONo Tuberculosis OYes ONo Osteoporosis OYes ONo Heart Attack/Failure Chest Pains OYes ONo Tumors or Growths OYes ONo OYes ONo Pain in Jaw Joints Heart Murmur OYes ONo Cold Sores/Fever Blisters OYes ONo OYes ONo Ulcers Parathyroid Disease ○Yes ○No Heart Pacemaker ○Yes ○No Congenital Heart Disorder Venereal Disease O Yes O No Psychiatric Care O Yes O No OYes ONo Heart Trouble/Disease OYes ONo Convulsions OYes ONo Yellow Jaundice If yes Have you ever had any serious illness not listed above? OYes ONo 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:

Date:

PATIENT REGISTRATION

First Name: Last Name: Middle Initial: Patient El, Policy Holder Responsible Party Preferred Name: Responsible Party (if someone other than the patient) First Name: Middle Initial: Middle Initial: Responsible Party (if someone other than the patient) First Name: Middle Initial: Middle Initial: Address: Address: Pager: Celtular: Drivers Lie:	ID:	Chart ID:					
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Patient Information Address: Address 2: City: State / Zip: Home Phone: Work Phone: Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Birth Date:	Birth Date:	Sec Sec:		Driv	ers Lic:		
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