

**PATIENT REGISTRATION**

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Single

Divorced  Separated

Widowed

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Emergency Contact \_\_\_\_\_

Emergency Contact # \_\_\_\_\_

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_

Prof. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_

Prof. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_

Prof. Hyg: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

SETON CENTER, INC  
**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, 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 <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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: \_\_\_\_\_

Patient Name \_\_\_\_\_

Record Number \_\_\_\_\_

## Seton Center, Inc.

### **Acknowledgement of Seton Center Notice of Privacy Practices**

Seton Center provides a detailed explanation of your rights and the practices guiding how information in the Seton Center database is treated. By signing this document you acknowledge that you have been offered and/or received a copy of the Notice of Privacy Practices, and have had an opportunity to review the Seton Center Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient/Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Seton Center, Inc.  
2816 E 23<sup>rd</sup> Street  
Kansas City, MO 64127

Consent for Treatment

I authorize the Seton Center dentist or other authorized staff, to provide treatment and/or consultation deemed appropriate for my care or care of my child. Furthermore, I understand that all medical documents, including x-rays, shall remain the property of Seton Center, Inc.

\_\_\_\_\_  
Patient/Parent or Legal Guardian Signature                      Date

~~Insurance assignments and benefits release~~

I, the undersigned, certify that I/my dependent have dental coverage with:

Dental Insurance Name: \_\_\_\_\_

and assign all authorized benefits payments to be made to Seton Center, Inc. on behalf of me/my dependent. Furthermore, I authorize the release of any information to any private payer, third party payer government agency responsible for the payment of benefits related to any submitted claims on my behalf or on behalf of my dependent. I agree to assume financial responsibility for all expenses of such care.

\_\_\_\_\_  
Patient/Parent or Legal Guardian Signature                      Date

In case of an emergency, please notify: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Telephone # \_\_\_\_\_

## Seton Center Patient Expectation and Responsibilities

Welcome to Seton Center. Our goal is to provide affordable, quality health and dental services. In order to achieve this goal, we work at and depend on honest and open communication with our patients. The purpose of this document is to establish an understanding between you and Seton Center about what can be expected from each other in relation to your dental care. Please read this document carefully, and do not hesitate to ask a staff member if you have any questions. You are asked to sign this document as part of your enrollment process.

Patients are expected to:

1. Provide complete and accurate information about yourself and your family. Inform Seton Center of any changes in family information.
2. Ask questions if you do not understand information you have received from a health care provider or a business office staff member.
3. Adhere to clinic guidelines, rules, dental care provider or staff instructions regarding relationship to Seton Center.
4. **Keep scheduled appointments, or notify us 24 hours in advance of the need to cancel. Not showing up or canceling appointments after 2 times, or missing one hygiene appointment will result in denial of services, unless you participate in patient obligation class.**
5. Refuse treatment if they wish not to receive treatment.
6. Treat Seton Center staff with respect and courtesy.
7. Bring concerns or complaints to the attention of the staff.
8. Pay your bill at the time of service. Part of the mission is to give a sliding scale discount to those who need it, however in order for the mission to remain in service; your bill must be paid within a reasonable time and should at no time exceed \$50.00 owed if you are on a sliding scale or full pay.
9. Patient must confirm appointment the day before. If not, your appointment will be given to someone else.
10. If you change phone numbers please give us a call with your new number. If you number has been disconnected, you must notify us.
11. The patient is the only one allowed in the operatory. Caseworkers must stay in the consultation room.

Patients can expect Seton Center staff to:

1. Treat you with respect, courtesy, and appropriate privacy.
2. Treat information that you provide confidentially.
3. Provide an explanation of any question that you may have regarding your care, bill, or other services provided by Seton Center.
4. Adequately inform you of the options available related to your care and payment obligations.
5. Work earnestly with you in setting affordable and fair payment arrangements for fees that you owe.
6. Listen to concerns and complaints that you have and to make any possible changes to rectify the situation.
7. Provide you with a written explanation before any services are changed.
8. We will try to call and confirm your appointment the day before.

\_\_\_\_\_  
Patient, Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date