KEVEN P. ARNOLD
DENTISTRY

dr. KEVEN ARNOLD
sleep center

PATIENT REGISTRATION

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: _____

Address: _____ Address #2: _____

City, State, Zip: _____

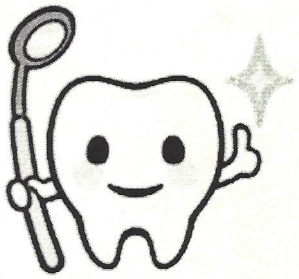
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____

E-mail Address: _____



Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address #2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec: _____

Primary Insurance Information

Name of Insured: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address #2: _____

City, State, Zip: _____

Ins. Company: _____

Address: _____

Address #2: _____

City, State, Zip: _____

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St. Charles, IL 60174
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E office@arnolddds.com
www.arnolddds.com
www.arnoldsleep.com

Your dental health...
Vital to whole body health

Sleep....vital to whole body health

Keven P. Arnold, DDS, PC

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	

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 use controlled substances? ○ Yes ○ No 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 ○ 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:_____

[DR. KEVEN ARNOLD D.D.S. P.C.]
2020 Dean St. Suite C St. Charles, IL 60174 | (630)443-4545

Financial Policy

We'd like to take this opportunity to welcome you to our practice and to familiarize you with our office billing policies. Please take a moment to read the following information, then sign at the bottom of the page and return it to the front desk.

While we are happy to submit your insurance claim for you, charges for any balances remaining are your responsibility. Your estimated portion, including any deductibles that apply is due at the time of service and must be paid in full.

It is your responsibility to notify this office of any change in your insurance coverage or carrier. We will require a photocopy of your insurance card at the time of your visit and request that you do your part by keeping track of your dental maximums when scheduling treatment.

If your balance becomes past due, we will take all necessary steps to collect this debt. In the event that the balance for treatment completed is not received, you agree to pay any costs of collection including attorney fees which incur, plus all court costs.

We thank you in advance for your cooperation with our policies.

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that signing this consent form, I authorize Dr. Keven Arnold to use and disclose my protected health information to carry out

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment form third party payers (e.g. insurance company)
- Day-to-day healthcare operations of the practice (email/text reminders/confirmations of appointments via online services)

I have also been informed of, and given the right to review, a copy of your Notice of Privacy practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Dr. Keven Arnold reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed Name: _____

Signature: _____ Date: _____

DR. KEVEN ARNOLD
PATIENT COMMUNICATION CONSENT FORM

PATIENT NAME _____
DATE OF BIRTH _____

I agree to allow Dr. Keven Arnold and staff to contact me in the following methods regarding my private health information, evaluation and treatment, appointment reminders, insurance questions, and payment details.

	Method	Number/Address	Message (Yes or No)	
___	Home Phone	(___)_____	◯ Yes	◯ No
___	Cell Phone	(___)_____	◯ Yes	◯ No
___	Work Phone	(___)_____	◯ Yes	◯ No
___	Alt. Phone	(___)_____	◯ Yes	◯ No
___	Text Messages	(___)_____	◯ Yes	◯ No
___	E-Mail	_____	◯ Yes	◯ No

I authorize Dr. Keven Arnold and staff to also contact me regarding the health information, evaluation and treatment, appointment reminders, insurance questions and payment details for the following members of my family.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

By my signature below I acknowledge that I have read and understand the patient communication and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibility.

_____ _____

Patient Name Printed DATE

_____ _____

Patient/Authorized Signature Relationship to patient