

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: _____

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

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Referred By _____
Previous Dentist _____
Emergency Contact _____
Emergency Contact # _____

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: _____



Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health.

The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment.

Payment Options

- Payment is due at the time services are provided. Our office accepts cash, check, American Express, Discover, Mastercard and Visa.
- If you need to make long term payments we can offer financing through Care Credit. One of our team members will be happy to help you with the application process. You must qualify prior to treatment to use this financing option.
- We reserve the right to charge a \$35.00 fee on all returned checks.

Patients with Dental Insurance

- We are a non-participating provider (out of network) for all dental insurance companies, other than Cigna PPO and DHMO.
- If you are covered under a dental policy, please be prepared to present your dental insurance card, employer and subscriber information (name, date of birth and social security number) before your appointment. Eligibility will be verified before being seated in the treatment room.
- As a courtesy, we will file your insurance claims. Upon request, we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. You are responsible for monitoring the amount of your remaining benefits for any annual benefit period. Please contact your insurance company for a detail of your benefits.
- Insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; it often does not cover all the cost involved in treatment. Any deductible or co-payment amount will be due at the time of treatment. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- **In some instances, insurance companies will not assign benefits (send payment) to an out of network provider.** If this is the case with your insurance company, you will be **required to pay the full amount at the time of your appointment.** You should receive reimbursement from your insurance company within 1-2 weeks. We will do our best to determine where benefits are assigned prior to your appointment. This typically applies to **BCBS of NC, BCBS Federal Government and Delta Dental insurance policies.**

Appointment Policy

- At Marion DDS, we put faith in you to keep your appointment. Appointments are reserved exclusively for you, and missed appointments are costly and do not allow other patients to be seen. It is our policy to require 24 hours advance notice for all appointment cancellations. A failed appointment fee of \$30.00 will be applied to any appointment without a 24 hour notice. We understand that true emergencies arise. If this is the case, the failed appointment fee may be waived at our discretion.

I have read and agree with the Patient Treatment and Financial Policy of Marion D.D.S.

Signature of Financially Responsible Party

Date

Printed Name of Financially Responsible Party

Printed Name of Patient



Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____
 _____ is authorized to release protected health information about the
 above-named patient in the following manner and or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative _____ Date _____

Marion D.D.S.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Last Updated July 22, 2013

HIPAA requires a dental practice to make a good faith effort to obtain a signed Acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

Marion D.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")**

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other: _____

Staff Member Signature

Date