

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: _____

Last Cleaning Appt
Dental concerns
Emergency Contact
Emer Contact #
Referred By
Last Xrays
Confirmation phone#

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: _____

Dental Solutions, LLC
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

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 <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 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: _____

DENTAL HISTORY

Have you ever had any complications or upsetting dental experience following dental treatment? Y N If yes, please explain: _____

Date of your last complete dental exam? _____ Name of Previous Dental Provider: _____

Have you ever seen a periodontist? Y N Family history of periodontal disease, gum disease, pyorrhea? Y N

Have you ever had orthodontic treatment (braces) or have your bite adjusted? Y N

Family history of extensive tooth decay? Y N Have you had oral surgery? Y N

Do you feel nervous or anxious about dental treatment? Y N If yes, please explain: _____

Would you like to keep your teeth all of your life? Y N

Are you happy with the appearance of your teeth? Y N If no what would you like to change?

Do you have any current dental problems/concerns? (please mark all that apply)

sensitive teeth loose teeth mouth odor or bad taste clicking or popping in jaw
 gums bleed or hurt change in bite food caught between teeth difficulty opening or closing mouth
 TMJ problems frequent headaches broken teeth missing teeth ill fitting partial/denture
 dry mouth /excessive thirst cold sores/blisters/oral lesions difficulty chewing clenching/grinding
 other: Explain _____

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 patients) health. It is my responsibility to inform the office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN _____ **Date:** _____

CONSENT FOR SERVICES

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to use anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any complication.

I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at time of service unless other financial arrangements have been made. In the event that agreed upon payments are not received by agreed upon dates, I understand that a 1.5% late charge will be applied to my account.

I hereby give Dr. Lauren Harmon and Dr. Brett Burris (Dental Solutions) the right and permission to use my photographs/slides for educational purposes

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN: _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Protected Health Information (PHI) **NOT** to be disclosed (if any): _____
(account info, contact info, medical info, etc...)

I authorize the release of my Protected Health Information (PHI) to:

Name: _____ Relationship: _____

By signing below, I acknowledge that I have received the Notice of Privacy Practices and give Dental Solutions permission to send appointment reminders via the U.S. Postal Service, email, and/or telephone.

Signature of patient or legal guardian

Date

In lieu of patient signature, I, _____, a staff member of Dental Solutions, state that the patient has been given our current Notice of Privacy Practices.

Practice Representative Signature

Date

OFFICE PAYMENT POLICY

The following is an outline of our office payment policies. Please take a few minutes to read them, and then sign below to acknowledge your understanding and acceptance of them.

Fees

Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, payment is due at the time services are rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required.

We accept cash, check (returned check fee \$25), Visa, MasterCard and Discover. We also offer financing options through a third party finance company with payment terms at competitive interest rates or up to 12 months at no interest (CareCredit).

Insurance

As a courtesy to our patients with insurance, we will file your insurance claim and allow you to pay only your deductible and/or estimated co-payment as services are rendered. Please remember that the contract is with your insurance company and that your total balance in our office is always your responsibility. We make every effort to give you an accurate estimate of what your portions of our fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. If our office is not a preferred provider for your dental plan, you may still use your insurance, but you may not receive full benefits from your insurance company. It is your responsibility to determine if this office is a preferred provider for your insurance plan. Our office only performs composite resin restorations (tooth colored). The patient is responsible for the difference if the insurance chooses to pay for an alternative benefit.

Past Due Accounts

Account aging begins the day your charges are incurred. Accounts that are ninety days past due will be turned over to a third party collection agency. This action will cause an additional fee of 45% of your unpaid balance. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer be responsible for your family's dental care.

I have read, understand and agree to adhere to the financial policies outlined above.

Signature of Patient or Responsible Party

Date