Eagle DENTAL CARE

Patient Registration

Patient Information:

First Name _____ Middle Initial _____Last_____
Address_____City_____State_____Zip_____
Email Address_____SS#_____DOB_____
Home Phone_____Work_____Cellular_____
Employer_____ Employer Phone_____
Spouse Name_____SS#_____DOB_____
Spouse Employer _____Spouse Employer Phone_____
Who may we thank for referring you? _____

Parent or Legal Guardian Information

First Name _____Middle Initial_____ Last_____
Address_____City_____State_____Zip_____
Email address_____SS#_____DOB_____
Home Phone_____Work_____Cellular_____
Employer_____ Employer Phone_____
Relationship to patient_____

Insurance Information

Insurance Name _____Group Number_____
Policyholder Name _____Identification#_____
Employer _____Relationship to patient_____

Additional Insurance _____Group Number_____
Policyholder Name_____Identification#_____
Employer _____ Relationship to patient_____

I authorize my insurance benefits to be paid directly to the provider of service:

Patient Printed Name_____Date_____

Patient, Parent/Legal guardian Signature _____Date_____

Medical History

Dental History

Patient Name: _____

Other family members seen by us _____ Past/Current Dentist _____

Have you ever had any complications after dental treatment? □ yes □ no

If yes, please explain: _____

_____

Do you like your smile? □yes □no would you like whiter teeth? □yes □no

Would you like straighter teeth? □yes □no Do you feel you have bad breath? □yes □no

Do you think you clench/grind? □yes □no Do your gums bleed when you brush/floss? □yes □no

Health History

Please List any **PRESCRIPTIONS, OVER THE COUNTER, OR VITAMINS** you are taking:

_____

_____

_____

Do you or have you ever had any of the following? Please check those that apply: y

- ○ AIDS/HIV
- ○ Alcohol/Drug addiction
- ○ **Angina/Chest Pain**
- ○ Anemia
- ○ Arthritis/Rheumatism
- ○ **Artificial Joint**
- ○ Asthma
- ○ Blood Disease
- ○ Bleeding Problems
- ○ Heart Murmur
- ○ Hepatitis
- ○ Osteoporosis
- ○ Diabetes
- ○ Dizziness
- ○ Lung Disorder
- ○ Epilepsy
- ○ Glaucoma
- ○ Growth/Tumor
- ○ Head Injury
- ○ **Heart Attach/Stroke**
- ○ **Heart Disease**
- ○ Rheumatic Fever
- ○ Migraines
- ○ Other _____
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Disorders
- ○ Nervous Disorders
- ○ **Pacemaker**
- ○ **Prosthetic Heart Valve or Valve Replacement**
- ○ **Radiation Treatment**
- ○ **Chemotherapy**
- ○ **Pre-Med Required**
- ○ **Cancer_____**
- ○ Sinus Problems
- ○ Snoring/Sleep Apnea
- ○ Stomach Problems
- ○ Tobacco Use
- ○ Transplant _____
- ○ Tuberculosis TB
- ○ Thyroid Disease
- ○ Ulcers
- ○ Shingles
- ○ **High Blood Pressure**

○ **Allergies:** □ Codeine □ Iodine □ Latex □ Sulfa □ Penicillin □ Hay Fever □ Other_____

Have you ever or are you currently taking and Bisphosphonates medications (*Fosamax, Zometa, Actonel, Boniva*) to increase bone density for osteoporosis? □yes □no

Have you been hospitalized or needed emergency care in the last 5 years? □yes □no

If yes, please explain: _____

_____

Are you now under the care of a physician? □yes □no

If yes, please explain: _____

WOMEN: Are you pregnant? □yes □no Are you nursing? □yes □no

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next visit without fail.

Patient Printed Name_____Date_____

Patient, Parent/Legal guardian Signature _____Date_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Please list who we may discuss treatment with:
Name: _____ Relationship to patient:_____

Name: _____ Relationship to patient:_____

Name: _____ Relationship to patient:_____

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient, Parent/Legal guardian Signature _____Date_____

Patient Printed Name_____Date_____

ELECTRONIC NOTIFICATIONS
I agree that Eagle Dental Care may communicate with me electronically at the e-mail address/phone number provided.

EMAILING X-RAYS
In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool while allowing you access to quicker services. I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Patient Printed Name_____Date_____

Patient, Parent/Legal guardian Signature _____Date_____

Payment Policy

Financial Agreement

Thank you for choosing Eagle Dental Care. We are committed to excellence, and we feel that you deserve nothing less when it comes to your dental health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs to have open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits we will submit your claims to your insurance company. Any portion that is not expected to be covered by these benefits is the **responsibility of the patient and is due at the time services are rendered.** This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the differences and **payment is due within 30 days.**

Dental benefits are contracts between the policy holder and the insurance company. We will make every effort to assist you with any benefit questions, however we suggest that you be aware of individual policy clauses, such as waiting periods and of what benefits you have available. Ultimately, you are responsible for any unpaid balance. We want you to be comfortable with our team. If you ever have any questions about your dental treatment financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Marital status is not a consideration under any circumstances. Decreed custody or lack thereof, does not alter any financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide to the other parent for reimbursement.

There is a **$35.00** charge for all returned checks. If a check is returned and not paid within 7 days of return date, legal action may be taken for collection. Any costs associated with collection of returned checks will be assumed by you. In the event that your account becomes delinquent, you will be responsible for all collection fees, attorney fees, and court costs.

For your convenience we do accept many forms of payment including cash, check, Visa, MasterCard, American Express, and we also offer third party financing, which includes interest free programs. Ask our staff for details.

Broken Appointment Policy

We understand how valuable your time is, so we make every effort to remain on time. Your scheduled appointment is reserved exclusively for you. We have a 24 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require a reservation to be rescheduled. If sufficient notice is not given, your account will automatically be charged a **$50.00 missed reservation fee**. We ask that you make every effort to keep your reserved time.

Patient Printed Name_____Date_____

Patient, Parent/Legal guardian Signature _____Date_____