PATIENT INFORMATION

The following information is necessary for proper treatment & will be kept confidential

(Mr-Mrs-Ms-Miss-Dr) First: _____ Last: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Alt Phone: _____

Birthdate: _____ ☐ Male ☐ Female SSN: _____

Emergency Contact: _____

Phone: _____ Relationship to patient: _____

Name of Referring Dentist: _____

INSURANCE INFORMATION

PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD PRIOR TO APPOINTMENT!!

(If you have secondary insurance, please give receptionist your card)

Policy Holder's Name: _____

Relationship to patient: _____ DOB: _____ ID#: _____

Insurance Company: _____ Group #: _____

Person responsible for account/finances: _____

FINANCIAL AGREEMENT

PAYMENT IS DUE AT THE TIME OF SERVICE. FOR PATIENTS WITH DENTAL INSURANCE; AS A COURTESY, A CLAIM WILL BE FILED ON THEIR BEHALF. FINANCE CHARGES ARE ASSESSED 90 DAYS [AFTER THE INSURANCE PAYS] ON ANY REMAINING BALANCE.

Patients with dental insurance pay *estimated* portion at time of visit. **All insurance quotes are estimates** and NOT a guarantee of payment. Actual payment will depend on the Treatment Plan in effect at the time of service. Any difference of payment leftover after insurance is solely the responsibility of the patient/responsible party.

I further authorize my insurance company and/or benefits administrator to pay these assigned benefits directly to Dansie Hepworth Dental. I understand I am financially responsible for any charges, whether or not paid by my insurance and/or benefits administrator, and that Dansie Hepworth Dental will submit billings to my insurance company and/or benefits administrator as a courtesy for me. Unpaid balances, exceeding 6 months, may be subject to referral to a collection agency for further debt resolution.

APPOINTMENT CANCELLATION/RESCHEDULING POLICY

We respectfully ask for a **24 HOUR NOTICE** of any appointment cancellation. A $50.00 fee will be added to each patient's account for any "No-Show" appointments or if we do not receive 24-hour notice for a cancelled appointment.

*HIPAA-PRIVACY PRACTICES:

I am aware of the Notice of Privacy Practices & I was provided an opportunity to review it. INITIAL: _____

ALL INFORMATION WRITTEN IS TRUE & COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

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, c

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	◯ 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 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:_____

Consent & Information Form

Work to be done:

- I understand that I am having the following work done: Fillings ___ Bridges ___ Crowns___ Extractions___ General Anesthesia ___ Exam, X-rays, and Cleaning ___

Drugs and Medications:

- I understand that antibiotics and analgesics and other medications can cause allergic reaction causing redness and swelling of the tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

Changes in Treatment Plan:

- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restoration procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Removal of Teeth:

- Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. The cost of which is my responsibility.

Crowns Bridges and Caps:

- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing a temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

Dentures Complete or Partial:

- I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problem of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

Endodontic Treatment (Root Canal)

- I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedure may be necessary following root canal treatment (apicoectomy)

Periodontal Loss (Tissue & Bone)

- I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that undertaking and dental procedures may have a future adverse effect on my periodontal condition. I understand that dentistry is not an exact science and that, therefore; reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the denial treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

I CONSENT TO THE PROPOSED TREATMENT

Signature of Patient (or Guardian): _____

Date: _____