Providence Dentistry

COSMETIC, IMPLANT AND FAMILY DENTISTRY

First Name_____Last Name _____Middle Initial_____

Preferred Name_____Patient is: Insurance Policy Holder ◯

Address _____

City, State, Zip_____

Home Phone_____CellPhone_____

Sex: M ◯ F ◯ Marital Status: Married ◯ Single ◯ Divorced ◯ Widowed ◯

Birthdate: _____Age____ Soc Sec#_____ Drivers Lic_____

E-Mail:_____

Responsible Party (If someone other than the patient)

First Name _____Last Name _____

Address_____

City, State, Zip_____Home Phone_____

Birthdate:_____Soc Sec#_____

Ins Member ID# _____

Responsible party is also an Insur policy for patient Y/N Primary INS. Y/N Secondary INS. Y/N

Primary Insurance Information

Name of Insured _____Related to Insured: self/spouse/child/other

Insured Soc Sec# _____Insured birthdate _____

Employer: _____Ins Company_____

Secondary Insurance Information

Name of Insured _____Related to Insured: self/spouse/child/other

Insured Soc Sec# _____Insured birthdate _____

Employer: _____Ins Company_____

Time 8:14 AM

PROVIDENCE DENTISTRY

Eaglesoft Medical History

Date 1/4/2017

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	○ 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:_____

Providence Dentistry

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Providence Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number)(i.e. Spouse, Parent, Grandparent, Stepparent, Relative, Friend etc.) ☐ _____ ☐ _____ ☐ _____	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder
☐ 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.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as describe 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.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

Financial Overview

Here at Providence Dentistry we feel the best thing about our style of dentistry is our commitment to quality. If you've been with our practice a while, you already know our attention to detail and fine materials are second nature to us. But everyone's financial situation is different.

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment of excellence to you. Our goal is to assist you in the settlement of your account with the same quality and professionalism that our dental care provides. We accept cash, check, Visa, MasterCard, and American Express and Discover. We also offer a healthcare financing program through Care Credit. Care Credit is a line of credit for your healthcare expenses and offers interest free payment options and extended payment options up to 60 months terms. Check Policy: for your convenience, if your check is dishonored or returned for any reason, we will debit your account for the amount of the check plus a processing fee of $25.00.

We will communicate clearly all recommended treatment and fees involved prior to beginning treatment. Our fees reflect the quality of care we provide to our patients. We shall do all within our power to help you satisfy your account.

Payment is required at time of services. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. Please be aware that the patient or guardian bringing a child to our office for treatment is responsible for payment of all services rendered.

For our patients with dental benefits, as a courtesy to you we will file your claims. We will gladly accept insurance benefits of assignments to help reduce immediate out of pocket expense. We require that the deductible, non-covered fees and the estimated patient portion to be paid at each visit.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately depict your coverage. Providing us with the information will facilitate future claims and communications to maximize your benefits. If you have a direct reimbursement policy, you will be asked to pay in full the day of service and your insurance company will reimburse you.

Important facts about your dental insurance

- Your dental insurance is a benefit to you and a contract between you, your employer and your insurance company.
- It is your responsibility to know the type of dental insurance you have (i.e.: Traditional, PPO, or DMO), and to know what benefits are offered under your plan.
- You (not the insurance company) are responsible for the fees of services rendered to you.
- We appreciate the opportunity to provide you with excellent dental care.

Patient/Parent/Guardian Signature: _____ Date: _____

Providence Dentistry

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

  _____

Prepared By _____

Signature _____

Date _____