2020 PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ **Date of birth:** _____

Sex: _____ **Age:** _____ **Marital Status: S/M/D/W (circle one)**

Home address: _____

City: _____ **State:** _____ **Zip:** _____

Mailing address (if different): _____

City: _____ **State:** _____ **Zip:** _____

E-mail: _____ **Driver's license #:** _____ **State:** _____

Home phone: ( )_____ **Cell: ( )**_____ **Work: ( )** _____

SS #: _____ **Employer/Occupation:** _____

Business Address: _____

Spouse's name: _____ **Phone: ( )** _____

Spouse's SS#: _____ **Spouse's Date of Birth:** _____

Emergency phone # (other than spouse): _____

INSURANCE INFORMATION:

Primary dental insurance: _____ **Group #** _____

Subscriber: _____ **SS# or Member ID:** _____

Secondary dental insurance: _____ **Group #:** _____

Subscriber: _____ **SS# or Member ID:** _____

I certify that all information I have given is true and correct to the best of my knowledge. I understand that I am responsible for payment of all services rendered at each appointment. Please be advised that account balances not paid after 30 days will accrue interest at the rate of 1.5%, 18% (APR). In the event of NONPAYMENT, I further agree to bear the cost of collection, and/or court costs and reasonable legal fees should this be required. If an appointment is cancelled less than 24 Hours in advance there will be a $35 charge for Hygiene appointments and $50 for Appointments on Dr. Harrisons schedule.

Patient Signature: _____ Date: _____
(18 years and older)
Responsible Party Signature:_____ Date: _____

2020
Medical Information

DENTAL HEALTH HISTORY:

Last Dental Visit: _____ Name of previous Dentist: _____

Location of previous Dentist: _____ Reason for today's visit: _____

Please answer below: (yes or no)

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids: _____ Cold foods or liquids: _____ Sweets: _____

Do you clench or grind your teeth? _____ Do your jaws ever feel tired? _____

Do you have any jaw symptoms or headaches upon awaking in the morning? _____

Do you snore or have you been diagnosed with sleep apnea? _____

SURGICAL HISTORY:

PLEASE LIST ANY MAJOR SURGERIES BELOW:

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

PLEASE LIST WHO DID YOUR SURGERIES

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

During the past 12 months, have you taken any of the following medications:

Antibiotics or Sulfa Drugs	[ ]	Bone Density Medication	[ ]	Heart Medication	[ ]
Blood thinners	[ ]	Insulin	[ ]	Nitroglycerin	[ ]
High Blood Pressure	[ ]	Aspirin	[ ]	Steroids	[ ]
Natural Remedies	[ ]	Supplements	[ ]	Other	[ ]

Please list all medications below:

_____

_____

_____

I certify that all of the information above is true and correct to the best of my knowledge.

Patient signature: _____ Date: _____

Time 9:38 AM

Harrison Dental _Associates

Date 1/8/2020

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:_____

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

Phone Number E-mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Y____ N____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y____ N____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Patient / Parent or Legal Guardian refused to sign form
- ☐ Other

Signature of Office Manager Date

Financial Policy

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)
Legal fees for collection services

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Witnessed By