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:_____

DEAN COSMETIC DENTISTRY CENTER
Advanced Technology in a Relaxing Environment

FINANCIAL / OFFICE POLICIES

Thank you for choosing Dean Cosmetic Dentistry for your dental needs. We pride ourselves on our thorough communication with you, our patient, to make sure all questions are answered & you have any & all information you may need regarding your treatment.

In order to enhance communication and promote understanding regarding this office's financial policies, please read the following information & provide your signature below indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the office manager.

INSURANCE POLICIES & PROCEDURES

Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our financial relationship is with you, not your insurance company.

We will do our best to **estimate** insurance coverage & patient portion due. As a courtesy to our patients, we diligently verify your personal insurance plan coverage to best **estimate** your office fees. Unfortunately, we are not able to figure an exact amount of payment by a simple insurance verification. To make sure we are in agreement, we highly encourage you to be educated on your personal insurance plan. If we are not an in-network provider, fees may vary due to a difference of fees in each plan and/or insurance carrier. Understanding your policy will help us communicate clearly, as your service provider, to create a treatment plan that is most accommodating to you. If your insurance company does not pay the full amount anticipated, the patient is responsible for the difference. If your insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, major credit card, and Care Credit.

If you do not wish for us to contact your insurance company personally, you are ultimately responsible for any unpaid balances your policy does not cover. *see the Insurance Policy for more details

PATIENT PAYMENT

Payment is due at the time services are rendered. Balances over sixty (60) days will incur an interest charge of 1.5% per month & after 90 days, an additional $5.00 rebilling fee per statement will be charged. Returned checks will have an additional fee of $25.00 added to the amount of the returned check. Payment is expected within 10 days after the statement date. Please contact the office manager for more information on any of the above payment options.

FINANCIAL ARRANGEMENT

When there is treatment beyond preventive care needed there will be a financial arrangement form completed and further discussion of insurance or out of pocket expense will be discussed.

REFUNDS FOR UNFINISHED TREATMENT

Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist.

CREDITS ON AN ACCOUNT

If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the credit or leave a credit on the account to be applied towards future treatment.

Patient/Parent/Guardian Initials _____

DEAN COSMETIC DENTISTRY CENTER
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MISSED APPOINTMENT FEE

Please remember that we have reserved this time especially for you. Therefore, we request at least a 48-hour notice in order to reschedule your appointment. A $63 fee will be charged to your account per failed appointment. This amount is not covered by insurance and is your responsibility.

INFORMED CONSENT

I am consenting for treatment for myself or I am the parent, guardian, or personal representative. There are no court orders now in effect that prohibits me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the patient named above, including but not limited to radiographs, administration of anesthetics, and all dental procedures which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days from the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

MEDICAL HISTORY

To the best of my knowledge, the Medical History form has 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.

INSURANCE ASSIGNMENT CONSENT

I certify that myself or my dependent is covered by dental insurance and assign directly to Donnie Dean, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use mine and/or my child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received or read a copy of the Dean Cosmetic Dentistry Notice of Privacy Practices.

We appreciate your loyalty and understanding our financial/insurance policies and procedures. We hope to always exceed your expectations and hope that these procedures will create a more positive relationship with our office and you. Thank you again for choosing us and we look forward to making your smile even more beautiful.

I have read, and understand the Dean Cosmetic Dentistry Center's Financial/Office policies.

Signature of Patient or Responsible Party

_____ **Date:** _____

Signature of Dean Cosmetic Dentistry

_____ **Date:** _____

DEAN COSMETIC DENTISTRY CENTER
Advanced Technology in a Relaxing Environment

Insurance Policy

As a professional courtesy to our patients, Dean Cosmetic Dentistry will attempt to verify your dental insurance prior to your appointment time. We will also bill your dental insurance for services at our office once the estimated out-of-pocket is collected on the day your treatment is rendered. We will do our best to verify your insurance benefits to help determine what coverage you have at our office and what your ***estimated*** patient portion will be. The ***estimated*** patient portion is due the day of service. If your insurance company does not render its portion within 45 days, the balance is the patient's responsibility.

Insurance is an agreement between you and your insurance company. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. We do not have access to negotiated and contracted fees specific to your group plan. Fees are established between the insurance carrier and the company or person purchasing the plan.

"In-Network" plans have a network of dentists with whom they have a signed contract. Patients may choose a dentist on their "in-network" list or choose a dentist outside the "network". Because an in-network provider accepts a payment fee schedule, the patient's out of pocket expenses may be higher if he/she chooses to go to a dentist not associated with that particular network. We are not able to determine an exact amount of the out-of-network cost because we do not have access to the reimbursement fee schedule.

IN-NETWORK PLANS WITH DEAN COSMETIC DENTISTRY ARE LISTED BELOW

Delta Dental PREMIER - We are contracted with Delta Dental **Premier**. If you have a PPO plan with Delta Dental, you are considered to be using your out-of-network benefits, however, there is a level of write-off with the PPO plan. The responsible party pays the estimated difference between the cost allowed by your plan and our contracted rate with Delta Dental Premier. There are many different Delta Dental Plans with different allowances. Fee schedules are not provided to our office. This could result in either a balance or a credit once your insurance pays our office.

CIGNA PPO - We are contracted with CIGNA PPO. If you have an individual, retiree or specialty plan with CIGNA, you are considered to be using your out-of network benefits. The responsible party will pay the estimated difference between the cost allowed by your plan and our contracted rate with CIGNA. There are many different CIGNA plans with different allowances. Fee schedules are not provided to our office. This could result in either a balance or a credit once your insurance pays Dean Cosmetic Dentistry.

Please note: All patients with MetLife, Blue Cross Blue Shield, or United Health Care insurance plans will be asked to pay 50% of the cost of treatment at the time of their appointment. We have found that these insurance plans vary in range of fee schedules that are reimbursed to the out-of-network providers. Until claims are processed and paid by your insurance provider, Dean Cosmetic Dentistry has no way to verify the exact amount that will be reimbursed. Once the payment is received for your insurance carrier, you may or may not have an additional cost due or a credit on your account. A copy of the EOB we receive from your insurance company should also be sent to the insurance subscriber.

It is important for you to have an understanding of your dental insurance coverage. This document is our attempt to avoid any financial misunderstandings of your potential out-of-pocket expense.

I have read, and understand the Dean Cosmetic Dentistry Center's Insurance policy.

Signature of Patient or Responsible Party

_____ **Date:** _____

Signature of Dean Cosmetic Dentistry

_____ **Date:** _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____