Newnan Periodontics, LLC

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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	Tonsilitis ○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 REGISTRATION

First Name: _____ **Last Name:** _____ **Middle:** _____

Preferred Name: _____

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ □ I would like to receive email correspondences

Patient Information (section 2):

Preferred Pharmacy: _____ Referred By: _____

Previous Dentist: _____

Emergency Contact: _____ Phone #: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Patient consent to receive mail and/or telephone messages

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

Email Address (please print)

Do we have your permission to?

Send a recall appointment reminder to your house: 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 information and medical information with the person/s named below:

Name relationship phone number

Name relationship phone number

Name relationship phone number

Please provide us with the best phone number (s) to reach you at in the event of bad weather.

Phone number(s)

Acknowledgment of Receipt of Notice of Privacy Practices

I have received copy of the notice of Privacy Practices with an effective date of April 14, 2003

Signature of Patient /Parent or Legal Guardian Date

Consent for Services

In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay the reasonable value of said services to the Doctor. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my treatment.

All emergency dental services, or any dental services performed without insurance confirmation of eligibility must be paid for in cash, check or card at the time services are performed.

You will be responsible for payment of your estimated amount, including deductibles and co-pays of your primary dental insurance.

I understand that when a treatment plan is given to me, that those fees will be honored for a 12 month period only. I understand that there may be an increase in fees from the date of the treatment plan.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of patient, parent or guardian **Date**

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change or cancel an appointment, please give us at least **24-hour's notice** *(for any routine appointment)* **and/or 1 week notice** *(for any surgery appointment greater than **ONE** hour long)*. This courtesy makes it possible to give your reserved room to another patient who would like it.

If you cancel or fail to show for your confirmed SURGERY appointment, or if you arrive excessively late and treatment cannot be completed as planned, Dr. Faler reserves the right to recover lost opportunity and associated costs with a **BROKEN APPOINTMENT FEE OF $100 per ½ hour**** ; *(fee associated with ANY surgery appointment greater than 1 hour in length)*

One week prior to your appointment you will receive a phone call and/or an email requesting a verbal confirmation for your upcoming appointment. When you receive this message, please **CALL** us back to confirm the time that you have already reserved with us. **If we do not get a VERBAL confirmation from you 4-BUSINESS DAYS prior to your reserved time, we will take your appointment off of our schedule.**

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt; we, of course, would appreciate the same courtesy from you.

Late Arrival

If you are over **15 minutes** late for your appointment, we reserve the right to reschedule your appointment for a later time. Please understand that we strive to stay on time for your appointment as well as the patients that follow you. By signing below, you have read, and understand this agreement.

***We understand emergencies may arise and we will make allowances depending on the circumstances.*

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Signature of Patient or Parent **Date**

Financial Agreement

As a courtesy to our patients, we will file dental insurance claims for services rendered. However, you the patient are ultimately responsible for any incurred fees. We expect payment of deductibles, co-payments and balances to be made at the time services are rendered.

There are hundreds of dental insurance policies. Therefore, we are unable to know about all individual dental plans. In an effort to avoid confusion, we recommend the following:

- **Be familiar with your own policy.** Information to inquire about would be:
- Do you need to see a provider in your network?
- Does your policy have a yearly deductible and what is the amount?
- Does your policy have a waiting period or missing tooth clause?
- Know what your policy covers and what percentage of a procedure is covered.
- Know the frequency and timing of your preventative maintenance program (some policies cover two cleanings per calendar year and others only cover every six months)
- Know your policy year maximums and when the calendar year starts.
- **Bring correct insurance information to your appointment.**
  - Please provide us with your dental insurance ID card prior to the start of your appointment. We must have: policy, group and ID numbers to process your claim. We must also have the correct mailing address for your dental insurance carrier. If a claim is returned to us, you will be responsible for the fees and rendered services.
- **Let us know if a pre-authorization is required.** If a pre-treatment estimate is needed for treatment over $200, please inform us prior to starting the treatment. They usually take 6-8 weeks to respond to a claim.

Dr. Faler participates in Delta Dental, Cigna, Metlife and Ameritas. Even these plans have many policies within them, so make sure to know your plan. If you do not see our name on your list of providers, then we do not participate in your plan. However, some network plans allow you to see providers outside their networks. Your out-of-pocket expense may be slightly higher.

Dental insurance is meant to be an "aid" in receiving dental care. Our office bases treatment on your needs, not what your insurance will pay. Insurance payment is determined by "UCR" fees (usual, customary, and reasonable fees). These fees are not always the same as our fees. Some insurance companies may pay less, some pay more. Whether you're insurance pays 100%, 80%, or 50% of a procedure, they are determining payment based on **their** fee schedule, **not the actual fee** our office has charges for the service.

Filing insurance is not a guarantee of payment for the service(s) performed. We have no way of knowing if, or what, your insurance company will pay until the actual claim is submitted. Therefore, all account balances which have not been paid within a 30 day period become due by the person/parent/guardian that is responsible.

I have read the above information and agree to its terms:

_____ _____

Signature **Date**