



PRECISION
DENTAL & ORTHODONTICS

Welcome

Today's Date: ____/____/____

Patient's Name: _____

Preferred Name: _____ Male/Female

Birth Date: ____/____/____ Age: ____ SS # _____

Mailing Address: _____

City _____ State _____ Zip _____

Home # _____ Work # _____
Other # _____ Cell # _____

What days and times do you prefer your appointments?

Email Address: _____

How did you hear about us? _____

Employer: _____ How Long? _____

City _____ State _____ Zip _____

Occupation: _____

Approximately when was your last dental visit (**circle one**):
6 months 1 year 1-2 years 2-5 years 5-10 years

What were you treated for?

Where is your preferred pharmacy?

Name _____ City _____ State _____

Status: Minor/Single/Married/Divorced/Separated/Widowed
(Please Circle Answer)

Spouse's Name: _____

Do you have any children? Yes/No How Many? _____

Primary Dental Insurance

Insured's Name: _____

Relation: _____ DOB ____/____/____

Insured's Employer: _____

Co. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

Insured SS # _____

ID # _____

Group # (Plan, Local or Policy #) _____

Secondary Dental Insurance

Insured's Name: _____

Relation: _____ DOB ____/____/____

Insured's Employer: _____

Co. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

Insured SS # _____

ID # _____

Group # (Plan, Local or Policy #) _____

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Person ultimately responsible

Name: _____

Relation: _____

Billing Address: _____

City _____ State _____ Zip _____

SS#: _____

Driver's License # _____

Work # _____

Payment Method: Cash/Check/Credit Card

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Precision Dental Care
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

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 <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequen: Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequen: Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequen: Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> 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: _____

**ATTENTION ALL INSURANCE PATIENTS:
PLEASE READ THIS PAGE CAREFULLY IN ITS ENTIRETY!**

**AUTHORIZATION TO RELEASE
AND
AUTHORIZATION OF ASSIGNMENT OF BENEFITS**

We strongly feel that all patients deserve the very best dental care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

**OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, NOT THE INSURANCE COMPANY.
THEREFORE, PAYMENT FOR TREATMENT IS YOUR RESPONSIBILITY.**

Please read and sign the following:

- I authorize Precision Dental Care to release or receive any information necessary to expedite my insurance claims.
- I hereby authorize Precision Dental Care to bill my insurance company directly for their services.
- I authorize payment directly to Precision Dental Care of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Precision Dental Care for which these fees are payable.
- I understand that there are provisions and exclusions in my dental plan that may prevent payment for my procedures. I also understand that my insurance may not inform the provider of these provisions and exclusions upon benefit verification.

I understand that it is up to me to inform Precision Dental Care of my insurance eligibility, waiting periods and benefits. I also understand that this office cannot **guarantee** my insurance status in any of these areas. Any insurance estimate or information given to me by the staff at Precision Dental Care is **NOT** a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to be paid at that time.

Patient Signature _____

Date _____

Staff Signature _____

APPOINTMENT POLICY

We are glad you have chosen us to provide your dental care, but if you miss your appointments, you compromise your care. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show for an appointment without a phone call, or cancel without at least 24-hour notice.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the courtesy of a call when you are unable to keep your appointment.

In the event an appointment is failed without this 24 hour notice, a fee of \$25 will be charged to your account. We understand that circumstances arise and we will take these into consideration.

**I HAVE BEEN INFORMED OF AND AGREE TO COMPLY WITH THIS PAYMENT
AND APPOINTMENT POLICIES OF PRECISION DENTAL CARE**

Patient Signature _____

Date _____

Staff Signature _____

FINANCIAL POLICY

Our goal at Precision Dental Care is to provide the finest quality dental care available to our patients. We offer the best in sterilization, laboratory and clinical techniques currently used in the dental field today. We do not want this quality compromised by overhead expenses. In order to keep these expenses to a minimum, we ask the following: Payment is required at the time services are rendered. Payment can be made using the following payment types:

- Cash
- Personal/Local Checks. Local checks will be accepted with proof of driver's license of the person writing the check. **This person must be present at the time the check is written.** A \$35 service charge will be charged for all return checks.
- Credit Cards: Our office accepts most major credit cards
- Care Credit: No interest plans are available through an outside financing company for up to 12 months. They offer low monthly payments with no annual fees or pre-payment penalties. Please ask our Financial Coordinator if you are interested.

Please understand that beginning the first day of the month following balances becoming ninety (90) days past due, a monthly finance charge will be assessed to any unpaid balance. In the case of default of payment on this account, the responsible party agrees to pay collection costs and attorney fees incurred in attempting to collect in this amount or any future outstanding balances.

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 Dentist.

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

I accept full financial responsibility for this account and for all dentistry performed upon myself and my dependents in this dental office.

Patient Signature _____

Date _____

Staff Signature _____

ACKNOWLEDGMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such **Notice of Privacy Practices**. I understand that my dental provider has the right to change the **Notice of Privacy Practices** and that I may contact this office address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my privacy information is used and disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____