Eagle DENTAL CARE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ **Date of birth:** _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool while allowing you access to quicker services. I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

Medical History

Do you have other family members seen by us? ☐ Yes ☐ No If yes, please list: _____

Your past/current dentist: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you like your smile? ☐ Yes ☐ No Would you like whiter teeth? ☐ Yes ☐ No

Would you like straighter teeth? ☐ Yes ☐ No Do you feel you have bad breath? ☐ Yes ☐ No

Do you think you clench/grind? ☐ Yes ☐ No Do your gums bleed when you brush/floss? ☐ Yes ☐ No

Are you taking any over the counter/prescription drugs/herbal supplements/vitamins? ☐ Yes ☐ No

If yes, please explain _____

Do you or have you ever had any of the following? Please check all that apply:

☐ AID/HIV	☐ Kidney Disease	☐ Sinus problems	☐ Alcohol/drugs	☐ Dizziness
☐ Liver Disease	☐ Snoring/Sleep Apnea	☐ Angina/Chest Pain	☐ Lung Disorder	☐ Glaucoma
☐ Mental Disorders	☐ Stomach Problems	☐ Chemotherapy	☐ Epilepsy	☐ Asthma
☐ Tobacco use	☐ Nervous Disorders	☐ Shingles	☐ Pacemaker	☐ Hepatitis
☐ Heart Murmur	☐ Radiation Treatment	☐ Artificial Joint	☐ Growth/Tumor	☐ Ulcers
☐ Tuberculosis (TB)	☐ Head Injury	☐ Thyroid Disease	☐ Blood Disease	☐ Anemia
☐ Diabetes	☐ Heart Attack/Stroke	☐ Heart Disease	☐ Arthritis/Rheumatism	
☐ Rheumatic Fever	☐ Bleeding Problems	☐ Pre-med required	☐ High Blood Pressure	
☐ Prosthetic Heart Valve (or valve replacement)		☐ Severe/Frequent headaches		

☐ Transplant _____ ☐ Cancer _____ ☐ Other _____

Do you smoke? ☐ Yes ☐ No Do you have osteoporosis? ☐ Yes ☐ No

Have you ever or are you currently taking any Bishosphonate medications (Fosamax, Zometa, Actonel, Boniva) to increase bone density? ☐ Yes ☐ No

Have you been admitted to a hospital or needed emergency care during the past five years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____

Allergies ☐ Codeine ☐ Iodine ☐ Latex ☐ Sulfa ☐ Penicillin ☐ Hay Fever ☐ Other: _____

WOMEN Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next visit without fail.

_____ _____

Signature of patient, parent or guardian Date

Patient Registration

Date: _____

Patient Information

First Name: _____ Middle Initial: _____ Last:_____

Address: _____ City: _____ State: _____

Zip: _____ Email Address: _____ SS#: _____

DOB: _____ Home Phone: _____ Work: _____

Cell: _____ Employer: _____ Employer Phone: _____

Spouse Name: _____ SS#: _____ DOB: _____

Spouse Employer: _____ Spouse Employer Phone:_____

Who may we thank for referring you? _____

Parent or Legal Guardian Information

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

SS#: _____ DOB: _____ Home Phone: _____

Work: _____ Cell: _____ Employer:_____

Employer Phone: _____ Relationship to patient: _____

Insurance Information

Insurance Name: _____ Group Number: _____

Policyholder Name: _____ Identification #: _____

Employer: _____ Relationship to patient: _____

Additional Insurance: _____ Group Number: _____

Policyholder Name: _____ Identification #: _____

Employer: _____ Relationship to patient: _____

I authorize my insurance benefits to be paid directly to the provider of service:

Signature_____

Payment Policy

Thank you for choosing Eagle Dental Care for your dental needs. In an effort to provide you with quality care and to avoid any misunderstanding, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits , we will kindly submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the responsibility of the patient and due at the time service is rendered. This amount may include deductible and co-payments. If benefits amounts are less than expected, you will be billed for the difference and payment due within 30 days.

Dental benefits are contracts between the policy holder and the insurance company. We will make every effort to assist you with any benefit questions. However we suggest you be aware of individual policy clauses. Ultimately, you are responsible for any unpaid balance.

Marital status is not a consideration under any circumstance. Decreed custody of lack thereof does not alter financial responsibility. The parent accompanying the minor on the day of service will be considered the responsible party. We will gladly provide you with documentation which you may need to provide the other parent for reimbursement.

In the event your account becomes delinquent, you will be responsible for all collection fees, attorney fees and court costs.

For your convenience, we accept: cash, check, debit, major credit cards and various dental credit card payment programs, such as Care Credit.

We require a 24 hour notice for cancellation of appointments. A $25.00 reservation fee may be charged if 24 hour notice is not given.

NOTICE OF PRIVACY PRACTICES

I have received a copy of Eagle Dental Care's Notice of Privacy Practices.

Patient Printed Name_____ Date_____

Patient, Parent/Legal Guardian Signature _____ Date_____