HAYS
DENTAL GROUP

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| **Patients Name**<br>Last | | First | | M.I. |
| **Address**<br><br>Street | Apt | City | State | Zip |
| **Contact Info**<br>Home Phone | Cell | | Email | |
| **When and where is the best time to reach you?** | | | **Daytime Phone** | |
| **SSN** | **Birth Date** | **Marital Status**<br>M S D W | | Male Female |
| **Employer** | **Employers Address** | | **Work Phone** | |
| **Spouses Info**<br>Last Name | First | | **Spouse Employer and Work Phone** | |
| **If patient is a minor, give paren'ts or guardian's name and initial for permission to treat minor** | **Name:**<br>**Initials:** | | **Is there an immediate family member with you here today?**<br>Yes No Name | |

**HOW DID YOU HEAR ABOUT OUR OFFICE?**

## EMERGENCY INFORMATION

| | | | | |
|---|---|---|---|---|
| **Name of Emergency Contact:**<br>Last Name: | First Name: | | **Phone Number**<br>Home: | Cell: |
| **Address**<br><br>Street | Apt | City | State | Zip |

**Do you have dental insurance?** **Yes** **No** If Yes, please complete page 3

**If No, are you interested in Third Party Financing?** **Yes** **No**

## PLEASE TURN OVER FOR MEDICAL HISTORY

Comments or Concerns:

Time 4:57 PM | Hays Dental Group | Date 11/13/2014

# 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 ○ 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 ○ 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:
Hays Dental Group is a Non-contracted dental clinic. We CANNOT accept Medicaid or the BCBS affiliate with Medicaid

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DENTAL GROUP

## DISCLOSURE OF INSURANCE INFORMATION

**Insurance Company/Dental Benefit Plan Information**

Company/Plan Name:

| Address: | City, State, Zip: |
|---|---|

**Policyholder/Subscriber Information**

Policyholder/Subscriber Name

Last: First: Middle Initial: Suffix:

| Address: | City, State, Zip: |
|---|---|

| Birth Date: | Gender: | SSN or ID # : |
|---|---|---|

| Plan/Group Number: | **Employer Name:** |
|---|---|

**Patient Information**

Relationship to Policyholder/Subscriber (circle one): Self Spouse Dependent Child Other

**Additional Coverage (secondary insurance)**

Name of Policyholder/Subscriber

Last: First: Middle Initial Suffix:

| Birth Date: | Gender: | SSN or ID #: |
|---|---|---|

| Plan/Group Number: | Patient's relationship to this policy holder: ◯ Self ◯ Spouse ◯ Dependent ◯ Other |
|---|---|

Secondary Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**I understand that the contract is between myself and my insurance company. Hays Dental Group is a third party that will accept payment from my insurance company, but my insurance company has limitations that Hays Dental Group is not aware of.**
**I understand that I am responsible for all charges regardless of my insurance. I understand that my insurance has a yearly maximum and the treatment I need may exceed that yearly maximum.**
**I understand that Hays Dental Group cannot be held liable for information received via telephone, fax or online regarding my insurance coverage. Hays Dental Group has no more ability to determine benefits payable than I do as a patient.**

Patient/Guardian Signature _____

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DENTAL GROUP

# AGREEMENTS AND POLICIES

**Cancellation Policy**

Please help us deliver outstanding and timely dental care to you and busy patients like you! We know and appreciate that you want to achieve and maintain health, but sometimes lead a hectic life. We are happy to seek to find a convenient appointment time for you or to reschedule any appointment if needed. If you find that you need to change an appointment time, please provide us with TWO BUSINESS DAYS NOTICE. This ensures that other busy patients like you can be seen in a timely manner and helps keep costs down so that we may offer you affordable dental care.

Please know we may elect to charge a cancellation fee of up to half your scheduled visit for cancellations made with less than two business days' notice.

**Financial policy**

I understand that payment for care is due the day it is received and that Hays Dental Group will submit, if appropriate, dental benefit paperwork on my behalf. Unless prearranged, using one of our third party finance companies, unpaid balances will be assessed a 10% monthly fee. There is a $25.00 fee for all NSF checks. I further understand that if my account is delinquent over 180 days, then I am responsible for any collection agency costs, court costs and legal fees.

**Hippa Policy**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: 1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment) **Because I pay in full for a service out of pocket instead of, I have the right to request that you do not disclose treatment information for this service to my health plan.** 2. Obtaining payment from third party payers (e.g. my insurance company) 3. The day-to-day health care operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my **Protected Health Information (PHI)**, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may ask you for an electronic copy of my records. I understand that I have the right to request restrictions on how my **PHI** is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

# SIGNED CONSENT TO AGREEMENTS AND POLICIES

**(Cancellation Policy, Financial Agreement and Hippa Policy)**

I, the undersigned patient, hereby authorize the Hays Dental Group to perform the procedure(s) or course(s) of treatment listed below including but not limited to comprehensive evaluation of my oral condition, diagnostic tests, radiographs, diagnostic casts, cleaning of my gums and teeth and fluoride application if needed. I understand that the risks associated with cleaning of my gums and teeth include: tenderness of gums lasting several days after the cleaning, transient sensitivity of my teeth to temperature and soreness of my jaw from holding my mouth open.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I give my consent for the administration of any medication that may be required as a life-saving measure.

I attest to have read and agree to the Cancellation Policy, Financial Agreement and Hippa Policy.

_____
Date

_____ _____
Print Patient Name Patient/Guardian Signature