Welcome

Patient Information (CONFIDENTIAL)

Date: _____

First Name: _____ Middle Int: ____ Last Name: _____

Prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext ____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date: _____ Social Security #: _____ Drivers License #: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Employer: _____ Work Phone: _____ Cellular: _____

Insurance Information

Name of Insured: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Birth Date: _____ Insured Social Security #: _____

Name of Employer: _____ Work Phone: _____ Ext: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Birth Date: _____ Insured Social Security #: _____

Name of Employer: _____ Work Phone: _____ Ext: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

In the event of an emergency contact: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Time 2:27 PM

Ideal Smile Dentistry

Eaglesoft Medical History

Date 5/6/2014

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

Do you use controlled substances? ○ Yes ○ No If yes

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 ○ 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: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also 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: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature and acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Ideal Smile Dentistry

2979 Northlake Parkway Suite 100
Columbus, GA 31909

Welcome to our practice

We appreciate the trust you have placed in us

PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, CHECK, AND ALL MAJOR CREDIT CARDS.

INSURANCE:

Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility.

Our office will not enter into a dispute with your insurance company over your claim. The amount you are responsible to pay on the day of service is an ESTIMATE ONLY based on information provided by your insurance company. After your insurance has rendered payment you will be billed for any balance remaining. If at the end of 60 days, your insurance company had not paid, you are responsible for the entire balance.

In order to honor any insurance benefits, you must provide insurance identification (insurance cards, photo ID) and we must be able to verify the current benefits available.

OFFICE FEES:

If you present a check for insufficient funds or stop payment on an issued check, you will be charges a $60.00 processing fee.

If you must break an appointment with our office, we ask for a 24 hour notice of cancellation. If we do not receive 24 hour notice, we may charge a fee for the scheduled appointment based on the total amount of time reserved. This fee cannot be charges to your insurance company. If you repeatedly miss scheduled appointments, you may be asked to pursue treatment elsewhere.

I HAVE READ AND UNDERSTAND THE STATEMENTS OUTLINES ABOVE

Signed: _____ Date: _____

Ideal Smile Dentistry

2979 Northlake Parkway Suite 100
Columbus, GA 31909
706-257-7374

Patient's Name:_____ **Birthdate:**_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Ideal Smile Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments; extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising , allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____ _____

(print your name) (relationship) (date)

_____ _____

(your signature) (witness)