



PATIENT INFORMATION

Thank you for choosing us as your dental care provider. We look forward to caring for you!

Patient Information:

Patient Name (First Middle Initial Last): _____ DOB: ____/____/____

SS#: ____/____/____ Driver's Lic. # _____ Marital Status: *Single Married Divorced Widowed*

Address: _____

City _____ State _____ Zip code _____ Sex: Male Female

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Email Address _____

Opt-In Disclaimer: Eastland Family Dental sends out patient communications (i.e. appt. reminders) via email, cell, and landline info provided. We do not share your information with other parties. If you do not wish to receive our communications, you may opt-out at info@eastlandfamilydental.com or call us at 816-795-7007.

Responsible Party (Complete if responsible party is someone other than the patient):

Name (First Middle Initial Last): _____ Relationship: _____

SSN#: ____/____/____ Driver's Lic. # _____ DOB: ____/____/____

Address: _____

City _____ State _____ Zip code _____ Sex: Male Female

Employer _____

Emergency Contact Information:

Name: _____ Phone: _____

PRIMARY INSURANCE

Ins. Co: _____

Group #: _____

ID# _____

Phone #: _____

Name of Insured: _____

Relationship to patient: _____

SS#: ____/____/____ DOB: ____/____/____

Employer: _____

Phone: _____

SECONDARY INSURANCE

Ins. Co: _____

Group #: _____

ID# _____

Phone #: _____

Name of Insured: _____

Relationship to patient: _____

SS#: ____/____/____ DOB: ____/____/____

Employer: _____

Phone: _____

I hereby authorize the doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon diagnosis, I authorize the doctor to perform the recommended treatment agreed upon by me and to employ assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I understand I can ask for a complete narration of any possible risks of complications.

X _____ / ____ / ____

Patient Signature (or guardian)

Date:

MEDICAL HISTORY QUESTIONNAIRE

Patient name: _____

Physician name: _____ Phone: _____

Are you under a physician's care now? yes no Please list reason: _____

Are you taking any medications or supplements, over-the-counter or prescribed? yes no

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____

OR Medication List Attached

Have you ever been hospitalized or had a major operation? yes no

Please list: _____ Date: _____

Please list: _____ Date: _____

Do you smoke or use chewing tobacco? yes no Do you or have you used recreational or illegal drugs? yes no

Are you allergic or had an unusual reaction to any of the following?

Aspirin Penicillin Codeine Local anesthetic Acrylic Sulfa Latex Metal

Other _____

Women: Are you: pregnant/trying to get pregnant? nursing? taking oral contraceptives?

Do you have, or have you had, any of the following?

- | | | | |
|-------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis A, B or C (circle one) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsive seizures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemodialysis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Frequent headaches/migraines | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> STD/Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ/TMD |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Other _____ |

If you marked any of the starred items above, do you take a prophylactic antibiotic prior to dental procedures? yes no

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that providing incorrect information can be dangerous to my (or patient's) health. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

X _____ / /
Patient Signature (or guardian) **Date:**



DENTAL EVALUATION

Patient name: _____

Former dentist name: _____ Date of last visit: _____

What made you seek a new dentist? _____

Have you ever had any complications following dental treatment? yes no

If yes, please explain: _____

Do you have, or have you had, any of the following?

MOUTH

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| Bleeding sore gums | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unpleasant taste/bad breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning tongue/lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent blister, lip/mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling/lumps in mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ortho treatments (braces, Invisalign) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Biting cheeks/lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clicking/popping jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty opening or closing jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

TEETH

- | | | |
|---------------------|------------------------------|-----------------------------|
| Loose teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitive to hot | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitive to cold | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitive to sweets | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitive to biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Food impaction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clenching/grinding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shifting in bite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change in bite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Have you ever been told you have gum disease or periodontal disease? yes no

Have you had periodontal surgery? yes no Periodontist's Name: _____

Are you satisfied with your smile? yes no

If no, what would you like to change: _____

Are you interested in whitening your teeth? yes no

Have you ever considered cosmetic dentistry (veneers, shaping, etc.)? yes no

Are you interested in straightening your teeth? yes no

Are you interested in dental financing? yes no

If you're a tobacco user, are you interested in information about quitting the use of tobacco products? yes no N/A, non-user

Have you ever been diagnosed with TMJ? yes no

Do you have frequent pain or muscle tension in your jaw, head or neck? yes no

Have you ever worn a night guard/bite splint? yes no

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

Another Patient (please list name): _____ Cookie Call

Direct Mail (circle one): *Welcome to Neighborhood postcard* *Mailer of local businesses* *Oversized postcard*

Dentist (list name): _____ Email Employee (list name): _____

Insurance Internet Location School Outreach Social Media

Sponsorship/Gift Certificate Yellow Pages Other _____

FINANCIAL POLICY

Thank you for choosing us for your dental care needs. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients' financial capabilities.

PAYMENT POLICY:

Patient payment/co-payment is required in full at time of service.

This office does not extend personal lines of credit. A \$35.00 service fee will be charged on all returned checks. Fees incurred to collect payment will be billed to and payable by the patient's responsible party.

We offer several convenient payment options:

- Cash, personal check, or money order (5% discount for services over \$100)
- Visa / MasterCard / Discover / Debit Card
- CareCredit (no interest/short term and low interest/extended term plans available)

INSURANCE:

Our office is committed to helping patients maximize their benefits. As a courtesy to our patients, our office will file claims to the patient's insurance carrier when all current dental insurance information is provided. Our office recommends that each patient become familiar with their insurance coverage including deductibles, co-pays, and yearly maximums as each insurance company determines their own level of reimbursement. For major services, we can submit a pre-authorization, when requested.

Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. If you have any questions, our staff is always available to assist you.

MINORS:

Payment for services for the treatment of minors is the responsibility of the adult accompanying the minor and is due at time of service.

CANCELLED APPOINTMENTS:

Once an appointment has been made, that time has been reserved specifically for that patient. We understand that illness, emergencies, and bad weather occur. We ask our patients to give us 48 hours' notice, whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting to be seen.

As a courtesy, we provide our patients with a confirmation message (via email, text or voice) two weeks prior to their appointment, as well as a reminder 48 hours prior to their appointment to ensure they know the day and time and that they will indeed be present at their scheduled time. Patients who fail to give 24-hour notice of a cancelled appointment will be charged a cancellation fee of \$25.00. Please note that we allow for two (2) broken appointments within a 12 month period and patients that exceed or abuse our policy will be terminated from our practice.

FINANCIAL CONSENT:

I authorize and hereby request my insurance company to pay directly to Eastland Family Dental all insurance monies to which I am entitled for dental services. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to pay all charges to Eastland Family Dental not covered by this agreement.

X

/ /

Patient Signature (or guardian)

Date



NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

HIPAA (Health Insurance Portability and Accountability Act)

By signing below, you consent to the use and disclosure of your protected health information by Eastland Family Dental's doctors, staff, and business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please ask to see our Notice of Information Practices. You have the right to review our Notice prior to signing this Consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (816) 795-7007 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us.

Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your protected health information (PHI).

I have reviewed, understand and agree to the content of the Notice of Privacy.

Printed Name: _____ Date: _____

Signed Name: _____ Date: _____

If patient chooses not to sign the form, please specify reason below:

If patient chooses to authorize another individual to have access to their health information, they may list the authorized individuals below:

Name	Relationship
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Name	Relationship
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