EASTLAND FAMILY DENTAL

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:***

EASTLAND FAMILY DENTAL

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?

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

EASTLAND FAMILY DENTAL

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			TEETH		
Bleeding sore gums	☐Yes	☐No	Loose teeth	☐Yes	☐No
Unpleasant taste/bad breath	☐Yes	☐No	Sensitive to hot	☐Yes	☐No
Burning tongue/lips	☐Yes	☐No	Sensitive to cold	☐Yes	☐No
Frequent blister, lip/mouth	☐Yes	☐No	Sensitive to sweets	☐Yes	☐No
Swelling/lumps in mouth	☐Yes	☐No	Sensitive to biting	☐Yes	☐No
Ortho treatments (braces, Invisalign)	☐Yes	☐No	Food impaction	☐Yes	☐No
Biting cheeks/lips	☐Yes	☐No	Clenching/grinding	☐Yes	☐No
Clicking/popping jaw	☐Yes	☐No	Shifting in bite	☐Yes	☐No
Difficulty opening or closing jaw	☐Yes	☐No	Change in bite	☐Yes	☐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_____

EASTLAND FAMILY DENTAL

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, for patients with no insurance coverage 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 been 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*

EASTLAND FAMILY DENTAL

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOT ICE OF PRIVACY PRACTICES

CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name:_ _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑First Name Only ❑Proper Surname ❑Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_ _____

Name:_____ Relationship:_ _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑Cell Phone Confirmation
❑Text Message to my Cell Phone
❑Home Phone Confirmation
❑Email Confirmation
❑Work Phone Confirmation
❑**Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑Cell Phone Confirmation
❑Text Message to my Cell Phone
❑Home Phone Confirmation
❑Email Confirmation
❑Work Phone Confirmation
❑**Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑Phone Message
❑Text Message
❑Email
❑**Any of the Above**
❑**None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑❑It was emergency treatment
❑❑I could not communicate with the patient
❑❑The patient refused to sign
❑❑The patient was unable to sign because
❑❑Other (please describe)_____